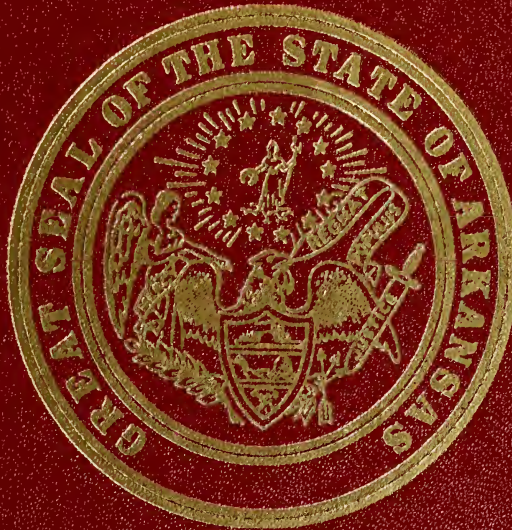


**ARKANSAS CODE
OF 1987
ANNOTATED**

OFFICIAL EDITION



VOLUME 24A • TITLE 23, CH. 74-87



Digitized by the Internet Archive
in 2013

ARKANSAS CODE OF 1987 ANNOTATED



VOLUME 24A

2004 Replacement

TITLE 23: PUBLIC UTILITIES AND REGULATED INDUSTRIES (CHAPTERS 74-87)

Prepared by the Editorial Staff of the Publisher

Under the Direction and Supervision of the
ARKANSAS CODE REVISION COMMISSION

Representative Steve Napper, *Chair*

Senator Gene Jeffress

Senator Sue Madison

Representative Will Bond

Honorable Douglas O. Smith, Jr.

Honorable William H. "Buddy" Sutton, Jr.

Honorable William G. Wright

Honorable Chuck Goldner, *Dean, University of Arkansas at
Little Rock, School of Law*

Honorable Richard Atkinson, *Dean, University of Arkansas at
Fayetteville, School of Law*

Honorable Tom Gay, *Senior Assistant Attorney General*

Honorable David Ferguson, *Assistant Director,
Bureau of Legislative Research*



LexisNexis™

COPYRIGHT © 1987, 1999, 2004

BY

THE STATE OF ARKANSAS

All Rights Reserved

LexisNexis, the knowledge burst logo, and Michie are trademarks of Reed Elsevier Properties Inc. used under license. Matthew Bender is a registered trademark of Matthew Bender Properties Inc.

4071712

ISBN 0-8205-8504-1



Matthew Bender & Company, Inc.

P.O. Box 7587, Charlottesville, VA 22906-7587

www.lexisnexis.com

Sources

This volume contains legislation enacted by the Arkansas General Assembly through the 2003 Regular Session. Annotations are to the following sources:

Arkansas Supreme Court and Arkansas Court of Appeals Opinions through 2003 Ark. LEXIS 413 (July 3, 2003) and 2003 Ark. App. LEXIS 575 (July 25, 2003).

Federal Supplement through July 25, 2003.

Federal Reporter 3d Series through July 25, 2003.

United States Supreme Court Reports, through July 25, 2003.

Bankruptcy Reporter through July 25, 2003.

Arkansas Law Notes through the 2001 Edition.

Arkansas Law Review through Volume 56, p. 497.

University of Arkansas at Little Rock Law Journal through Volume 25, p. 752.

Titles of the Arkansas Code

- | | |
|---|---|
| 1. General Provisions | 15. Natural Resources and Economic Development |
| 2. Agriculture | 16. Practice, Procedure, and Courts |
| 3. Alcoholic Beverages | 17. Professions, Occupations, and Businesses |
| 4. Business and Commercial Law | 18. Property |
| 5. Criminal Offenses | 19. Public Finance |
| 6. Education | 20. Public Health and Welfare |
| 7. Elections | 21. Public Officers and Employees |
| 8. Environmental Law | 22. Public Property |
| 9. Family Law | 23. Public Utilities and Regulated Industries |
| 10. General Assembly | 24. Retirement and Pensions |
| 11. Labor and Industrial Relations | 25. State Government |
| 12. Law Enforcement, Emergency Management, and Military Affairs | 26. Taxation |
| 13. Libraries, Archives, and Cultural Resources | 27. Transportation |
| 14. Local Government | 28. Wills, Estates, and Fiduciary Relationships |

User's Guide

Differences in language, subsection order, punctuation, and other variations in the statute text from legislative acts, supplement pamphlets, and previous versions of the bound volume, are editorial changes made at the direction of the Arkansas Code Commission pursuant to the authority granted in § 1-2-303.

Many of the Arkansas Code's research aids, as well as its organization and other features, are described in the User's Guide, which appears near the beginning of Volume 1 of the Code.

TITLE 23

PUBLIC UTILITIES AND REGULATED INDUSTRIES

(CHAPTERS 1-29 IN VOLUME 22; CHAPTERS 30-59 IN
VOLUME 23A; CHAPTERS 60-73 IN VOLUME 23B;
CHAPTERS 88-112 IN VOLUME 24B)

SUBTITLE 1. PUBLIC UTILITIES AND CARRIERS

CHAPTER.

1. GENERAL PROVISIONS.
2. REGULATORY COMMISSIONS.
3. REGULATION OF UTILITIES AND CARRIERS GENERALLY.
4. REGULATION OF RATES AND CHARGES GENERALLY.
- 5-9. [RESERVED.]
10. TRANSPORTATION OF PASSENGERS AND FREIGHT GENERALLY.
11. ESTABLISHMENT AND ORGANIZATION OF RAILROADS.
12. OPERATION AND MAINTENANCE OF RAILROADS.
13. MOTOR CARRIERS.
14. AIR COMMERCE REGULATIONS.
15. PIPELINE COMPANIES.
16. MISCELLANEOUS PROVISIONS RELATING TO CARRIERS.
17. TELEPHONE AND TELEGRAPH COMPANIES.
18. LIGHT, HEAT, AND POWER UTILITIES.
19. ELECTRIC CONSUMER CHOICE ACT OF 1999. [REPEALED.]
- 20-29. [RESERVED.]

SUBTITLE 2. FINANCIAL INSTITUTIONS AND SECURITIES

CHAPTER.

30. GENERAL PROVISIONS. [REPEALED.]
31. STATE BANK DEPARTMENT AND STATE BANKING BOARD. [REPEALED.]
32. GENERAL PROVISIONS.
33. INSOLVENCY AND LIQUIDATION. [REPEALED.]
34. MISCELLANEOUS VIOLATIONS OF BANKING LAWS. [REPEALED.]
35. CREDIT UNIONS.
36. INDUSTRIAL LOAN INSTITUTIONS.
37. SAVINGS AND LOAN ASSOCIATIONS.
38. BUILDING AND LOAN ASSOCIATIONS — MISCELLANEOUS PROVISIONS.
39. MORTGAGE LOAN COMPANIES AND LOAN BROKERS.
40. SALE OF PREPAID FUNERAL BENEFITS.
41. SALE OF CHECKS.
42. SECURITIES GENERALLY.
43. INVESTOR PROTECTION TAKEOVER ACT.
44. COMMODITIES FUTURES.
45. BANKING CODE OF 1997.
46. STATE BANK DEPARTMENT AND STATE BANKING BOARD.
47. BANK POWERS — SUBSIDIARIES.
48. ORGANIZATION AND OPERATION.
49. DISSOLUTION AND LIQUIDATION.
50. MISCELLANEOUS VIOLATIONS OF BANKING LAWS.

CHAPTER.

- 51. TRUST INSTITUTIONS.
- 52. CHECK-CASHERS ACT.
- 53. ARKANSAS HOME LOAN PROTECTION ACT.
- 54-59. [RESERVED.]

SUBTITLE 3. INSURANCE

CHAPTER.

- 60. GENERAL PROVISIONS.
- 61. STATE INSURANCE DEPARTMENT.
- 62. KINDS OF INSURANCE — REINSURANCE.
- 63. INSURANCE COMPANIES GENERALLY.
- 64. LICENSEES, AGENTS, BROKERS, ADJUSTERS, AND CONSULTANTS.
- 65. UNAUTHORIZED INSURERS AND SURPLUS LINES.
- 66. TRADE PRACTICES.
- 67. RATES AND RATING ORGANIZATIONS.
- 68. REHABILITATION AND LIQUIDATION OF INSURANCE COMPANIES.
- 69. DOMESTIC STOCK AND MUTUAL INSURERS.
- 70. RECIPROCAL INSURERS.
- 71. STIPULATED PREMIUM INSURERS.
- 72. MUTUAL ASSESSMENT LIFE AND DISABILITY INSURERS.
- 73. FARMERS' MUTUAL AID ASSOCIATIONS.
- 74. FRATERNAL BENEFIT SOCIETIES.
- 75. HOSPITAL AND MEDICAL SERVICE CORPORATIONS.
- 76. HEALTH MAINTENANCE ORGANIZATIONS.
- 77. AUTOMOBILE CLUBS OR ASSOCIATIONS.
- 78. BURIAL ASSOCIATIONS.
- 79. INSURANCE POLICIES GENERALLY.
- 80. INSURANCE POLICIES — SIMPLIFICATION.
- 81. LIFE INSURANCE POLICIES AND ANNUITIES.
- 82. INDUSTRIAL LIFE INSURANCE.
- 83. GROUP LIFE INSURANCE AND ANNUITIES.
- 84. STANDARD VALUATION LAW FOR LIFE INSURANCE AND ANNUITIES.
- 85. ACCIDENT AND HEALTH INSURANCE.
- 86. GROUP AND BLANKET ACCIDENT AND HEALTH INSURANCE.
- 87. MODEL ACT FOR THE REGULATION OF CREDIT LIFE INSURANCE AND CREDIT DISABILITY INSURANCE.
- 88. PROPERTY INSURANCE.
- 89. CASUALTY INSURANCE.
- 90. ARKANSAS PROPERTY AND CASUALTY INSURANCE GUARANTY ACT.
- 91. PREPAID LEGAL INSURANCE.
- 92. MULTIPLE EMPLOYER TRUSTS AND SELF-INSURED PLANS.
- 93. CONTINUING CARE PROVIDERS.
- 94. LIABILITY RISK RETENTION.
- 95. RISK-SHARING PLANS FOR PROPERTY AND CASUALTY INSURANCE.
- 96. ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.
- 97. LONG-TERM CARE INSURANCE.
- 98. MINIMUM BASIC BENEFIT POLICIES AND SUBSCRIPTION CONTRACTS.
- 99. HEALTH CARE PROVIDERS.
- 100. INSURANCE FRAUD INVESTIGATION DIVISION.
- 101. CREDITOR-PLACED INSURANCE.
- 102. ARKANSAS EARTHQUAKE AUTHORITY ACT.
- 103. TITLE INSURANCE AGENTS' LICENSING ACT.
- 104-109. [RESERVED.]

SUBTITLE 4. MISCELLANEOUS REGULATED INDUSTRIES

CHAPTER.

110. HORSE RACING.

111. DOG RACING.

112. MOTOR VEHICLE MANUFACTURERS, DEALERS, ETC.

SUBTITLE 3. INSURANCE

Effective Dates. Acts 1959, No. 148,
§ 697: 12:01 A.M., Jan. 1, 1960.

CASE NOTES

Waiver of Premiums.

The insurance code among other things gave the Insurance Commissioner the power to approve the form of policies; however, that act did not change the case law applicable to the waiver of premiums

during disability. J.C. Penney Life Ins. Co. v. Warren, 268 Ark. 1132, 599 S.W.2d 415 (Ct. App. 1980).

Cited: Cherry v. Tanda, Inc., 327 Ark. 600, 940 S.W.2d 457 (1997).

CHAPTER 74

FRATERNAL BENEFIT SOCIETIES

SUBCHAPTER.

1. STRUCTURE AND PURPOSE.
2. MEMBERSHIP.
3. GOVERNANCE.
4. CONTRACTUAL BENEFITS.
5. FINANCIAL.
6. REGULATION.
7. MISCELLANEOUS.

Publisher's Notes. Acts 1989, No. 881, § 1, effective January 1, 1990, "amended" this chapter by completely revising the chapter and replacing the former provisions with new provisions. Former § 23-74-129 was amended by Acts 1989, No. 772, § 15. The amendment substituted "biennial license fee of five dollars (\$5.00)" for "annual license fee of ten dollars (\$10.00)" in § 23-74-129(4)(A). The version of that section as amended by Acts 1989, No. 772 was effective until January 1, 1990.

The former chapter was derived from the following sources:

23-74-101. Acts 1959, No. 148, §§ 594-596; A.S.A., §§ 66-4701 — 66-4703.

23-74-102. Acts 1959, No. 148, § 637; A.S.A., § 66-4744.

23-74-103. Acts 1959, No. 148, § 634; A.S.A., § 66-4741.

23-74-104. Acts 1959, No. 148, § 635; A.S.A., § 66-4742.

23-74-105. Acts 1959, No. 148, § 636; A.S.A., § 66-4743.

23-74-106. Acts 1959, No. 148, § 597; 1963, No. 228, § 1; A.S.A., § 66-4704.

23-74-107. Acts 1959, No. 148, § 598; A.S.A., § 66-4705.

23-74-108. Acts 1959, No. 148, § 600; A.S.A., § 66-4707.

23-74-109. Acts 1959, No. 148, § 601; A.S.A., § 66-4708.

- 23-74-110. Acts 1959, No. 148, § 602; A.S.A., § 66-4709.
- 23-74-111. Acts 1959, No. 148, § 603; A.S.A., § 66-4710.
- 23-74-112. Acts 1959, No. 148, § 604; A.S.A., § 66-4711.
- 23-74-113. Acts 1959, No. 148, § 605; A.S.A., § 66-4712.
- 23-74-114. Acts 1959, No. 148, § 606; A.S.A., § 66-4713.
- 23-74-115. Acts 1959, No. 148, § 607; A.S.A., § 66-4714.
- 23-74-116. Acts 1959, No. 148, § 608; A.S.A., § 66-4715.
- 23-74-117. Acts 1959, No. 148, § 609; 1977, No. 550, § 4; A.S.A., § 66-4716.
- 23-74-118. Acts 1959, No. 148, § 610; 1985, No. 668, § 1; A.S.A., § 66-4717.
- 23-74-119. Acts 1959, No. 148, § 611; A.S.A., § 66-4718.
- 23-74-120. Acts 1959, No. 148, § 612; A.S.A., § 66-4719.
- 23-74-121. Acts 1959, No. 148, § 613; A.S.A., § 66-4720.
- 23-74-122. Acts 1959, No. 148, § 614; A.S.A., § 66-4721.
- 23-74-123. Acts 1959, No. 148, § 615; A.S.A., § 66-4722.
- 23-74-124. Acts 1959, No. 148, § 616; A.S.A., § 66-4723.
- 23-74-125. Acts 1959, No. 148, § 617; 1979, No. 942, § 14; A.S.A., § 66-4724.
- 23-74-126. Acts 1959, No. 148, § 618; A.S.A., § 66-4725.
- 23-74-127. Acts 1959, No. 148, § 619; A.S.A., § 66-4726.
- 23-74-128. Acts 1959, No. 148, § 620; A.S.A., § 66-4727.
- 23-74-129. Acts 1959, No. 148, § 621; 1983, No. 522, § 35; A.S.A., § 66-4728.
- 23-74-130. Acts 1959, No. 148, § 622; A.S.A., § 66-4729.
- 23-74-131. Acts 1959, No. 148, § 623; A.S.A., § 66-4730.
- 23-74-132. Acts 1959, No. 148, § 624; A.S.A., § 66-4731.
- 23-74-133. Acts 1959, No. 148, § 625; A.S.A., § 66-4732.
- 23-74-134. Acts 1959, No. 148, § 626; A.S.A., § 66-4733.
- 23-74-135. Acts 1959, No. 148, § 627; 1977, No. 551, § 7; 1979, No. 942, § 15; A.S.A., § 66-4734.
- 23-74-136. Acts 1959, No. 148, § 628; A.S.A., § 66-4735.
- 23-74-137. Acts 1959, No. 148, § 629; A.S.A., § 66-4736.
- 23-74-138. Acts 1959, No. 148, § 630; A.S.A., § 66-4737.
- 23-74-139. Acts 1959, No. 148, § 631; A.S.A., § 66-4738.
- 23-74-140. Acts 1959, No. 148, § 632; A.S.A., § 66-4739.
- 23-74-141. Acts 1959, No. 148, § 633; A.S.A., § 66-4740.
- Effective Dates.** Acts 1989, No. 881, § 2: Jan. 1, 1990.

RESEARCH REFERENCES

Am. Jur. 36 Am. Jur. 2d, Frat., § 1 et seq.

SUBCHAPTER 1 — STRUCTURE AND PURPOSE

SECTION.

- 23-74-101. Fraternal benefit society defined.
- 23-74-102. Lodge system.
- 23-74-103. Representative form of government.

SECTION.

- 23-74-104. Definitions.
- 23-74-105. Purposes and powers.
- 23-74-106 — 23-74-141. [Repealed.]

23-74-101. Fraternal benefit society defined.

Any incorporated society, order, or supreme lodge, without capital stock, including one exempted under § 23-74-704(a)(2), whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with

ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Fraternal Benefit Society.

Organization held to be a "fraternal benefit society." *United Order of Good Samaritans v. Meekins*, 155 Ark. 407, 244 S.W. 439 (1922) (decision under prior law).

Building of reserve so as to make it solvent did not take away character of fraternal benefit society. *Modern Woodmen of Am. v. State ex rel. Attorney Gen.*, 193 Ark. 458, 103 S.W.2d 38 (1937); *Sovereign Camp, W.O.W. v. Mays*, 195 Ark. 876, 115 S.W.2d 851 (1938) (preceding decisions under prior law).

Fact that appellant paid its officers and agents substantial salaries or compensation by way of commissions did not show that it was doing business for profit so as to take it without the operation of former similar provision. *Modern Woodmen of Am. v. State ex rel. Attorney Gen.*, 193 Ark. 458, 103 S.W.2d 38 (1937); *Sovereign*

Camp, W.O.W. v. Mays, 195 Ark. 876, 115 S.W.2d 851 (1938) (preceding decisions under prior law).

Association held not to be a fraternal benefit society. *Locomotive Eng'rs Mut. Life & Accident Ins. Ass'n v. Vandergriff*, 192 Ark. 244, 91 S.W.2d 271 (1936) (decision under prior law).

The character of policies issued by foreign fraternal benefit society, such as whole life certificates, ordinary life policies, term insurance, income policies, and endowment policies, did not prevent the society from operating under former similar act. *Modern Woodmen of Am. v. State ex rel. Attorney Gen.*, 193 Ark. 458, 103 S.W.2d 38 (1937); *Sovereign Camp, W.O.W. v. Mays*, 195 Ark. 876, 115 S.W.2d 851 (1938) (preceding decisions under prior law).

23-74-102. Lodge system.

(a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least one (1) time in each month in furtherance of the purposes of the society.

(b) At its option, a society may organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Cited: *Ferguson v. Order of United Com. Travelers of Am.*, 307 Ark. 452, 821 S.W.2d 30 (1991).

23-74-103. Representative form of government.

A society has a representative form of government when:

(1) It has a supreme governing body constituted in one (1) of the following ways:

(A) ASSEMBLY.

(i)(a) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws.

(b) A society may provide for election of delegates by mail.

(c) The elected delegates shall constitute a majority in number and shall not have fewer than two-thirds ($\frac{2}{3}$) of the votes and not fewer than the number of votes required to amend the society's laws.

(ii)(a) The assembly shall be elected and shall meet at least one (1) time every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly.

(b) Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(B) DIRECT ELECTION.

(i) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws.

(ii) A society may provide for election of the board by mail.

(iii) Each term of a board member may not exceed four (4) years.

(iv) Vacancies on the board between elections may be filled in the manner prescribed by the society's laws.

(v) A person filling the unexpired term of an elected board member shall be considered to be an elected member.

(vi) The board shall meet at least quarterly to conduct the business of the society;

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly; and

(4) Each voting member shall have one (1) vote. No vote may be cast by proxy.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Cited: *Ferguson v. Order of United Com. Travelers of Am.*, 307 Ark. 452, 821 S.W.2d 30 (1991).

23-74-104. Definitions.

As used in this chapter:

(1) "Benefit contract" means the agreement for provision of benefits authorized by § 23-74-401, as that agreement is described in § 23-74-404(a);

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract;

(3) "Certificate" means the document issued as written evidence of the benefit contract;

(4) "Laws" means the society's articles of incorporation, constitution, and bylaws, however designated;

(5) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches, or by any other designations;

(6) "Premiums" means premiums, rates, dues, or other required contributions by whatever name known, which are payable under the certificate;

(7) "Rules" means all rules, regulations, or resolutions:

(A) Adopted by the supreme governing body or board of directors; and

(B) Which are intended to have general application to members of the society; and

(8) "Society" means fraternal benefit society, unless otherwise indicated.

History. Acts 1989, No. 881, § 1.

23-74-105. Purposes and powers.

(a) A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing benefits as specified in § 23-74-401; and

(2) Operating for one (1) or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others. These purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to, or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

History. Acts 1989, No. 881, § 1.

23-74-106 — 23-74-141. [Repealed.]

Publisher's Notes. For information regarding the revision of this chapter, effective January 1, 1990, see the Publisher's Notes at the beginning of this chapter.

SUBCHAPTER 2 — MEMBERSHIP

SECTION.

23-74-201. Qualifications for membership.

23-74-202. Location of office, meetings, communications to mem-

SECTION.

bers, grievance procedures.

23-74-203. No personal liability.

23-74-204. Waiver.

23-74-201. Qualifications for membership.

(a) A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than fifteen (15) years of age and not greater than twenty-one (21) years of age;

(2) The process for admission to membership for each membership class; and

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

History. Acts 1989, No. 881, § 1.

23-74-202. Location of office, meetings, communications to members, grievance procedures.

(a)(1) The principal office of any domestic society shall be located in this state.

(2)(A) The meetings of its supreme governing body may be held in any state, district, province, or territory wherein the society has at least five (5) subordinate lodges.

(B) All business transacted at the meetings shall be as valid in all respects as if the meetings were held in this state.

(C) The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b)(1)(A) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. The required reports, notices, and statements shall be printed conspicuously in the publication.

(B) If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one

(1) member is deemed to be mailed to all members at the address unless a member requests a separate copy.

(2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, the synopsis may be published in the society's official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members.

History. Acts 1989, No. 881, § 1.

23-74-203. No personal liability.

(a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b)(1) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, the person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society.

(2) A person shall not be so indemnified or reimbursed:

(A) In relation to any matter in such action, suit, or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society; or

(B) In relation to any matter in such an action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful.

(3)(A) The determination whether the conduct of such a person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subdivision (b)(2) of this section may be made only by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, suit, or proceeding or by a court of competent jurisdiction.

(B) The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such a person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement.

(C) The right of indemnification and reimbursement provided in this subsection shall not be exclusive of other rights to which such a person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such a person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

History. Acts 1989, No. 881, § 1.

23-74-204. Waiver.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such a provision shall be binding on the society and every member and beneficiary of a member.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Foreign Companies.

Former identical section was applicable to foreign as well as domestic societies.

Sovereign Camp, W.O.W. v. Newsom, 142 Ark. 132, 219 S.W. 759 (1920) (decision under prior law).

SUBCHAPTER 3 — GOVERNANCE

SECTION.

- 23-74-301. Organization.
- 23-74-302. Amendments to laws.
- 23-74-303. Institutions.
- 23-74-304. Reinsurance.

SECTION.

- 23-74-305. Consolidations and mergers.
- 23-74-306. Conversion of fraternal benefit society into mutual life insurance company.

23-74-301. Organization.

A domestic society organized on or after January 1, 1990, shall be formed as follows:

(1) Ten (10) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(A) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(B) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter; and

(C) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election, at which all such officers shall be elected by the supreme governing body. The election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority;

(2)(A)(i) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the Insurance Commissioner, who may require such further information as the commissioner deems necessary.

(ii) The bond with sureties approved by the commissioner shall be in such amount, not less than three hundred thousand dollars (\$300,000) nor more than one million five hundred thousand dollars (\$1,500,000), as required by the commissioner.

(iii) All documents filed are to be in the English language.

(B) If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as provided in this section;

(3)(A) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the commissioner upon cause shown, unless the five hundred (500) applicants required by this section have been secured and the organization has been completed as provided in this section.

(B) The articles of incorporation and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as provided in this section;

(4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of such an advance premium, nor issue any certificate,

nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(A) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants and any necessary evidence of insurability has been furnished to and approved by the society;

(B) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(C) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums therefor; and

(D)(i) It shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such a society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as provided in this section. The premiums in the aggregate shall amount to at least one hundred fifty thousand dollars (\$150,000).

(ii) The advance premiums shall be held in trust during the period of organization, and if the society has not qualified for a certificate of authority within one (1) year, as provided in this section, the premiums shall be returned to the applicants;

(5)(A) The commissioner may make such examination and require such further information as the commissioner deems advisable.

(B)(i) Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter.

(ii) The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate.

(iii) The commissioner shall cause a record of the certificate of authority to be made.

(iv) A certified copy of such a record may be given in evidence with like effect as the original certificate of authority; and

(6) Any incorporated society authorized to transact business in this state on January 1, 1990, shall not be required to reincorporate.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Assessments.

Insured was not entitled to complain of additional assessment where former law similar to subdivision (4) of this section was in force when the policy was issued

and she had agreed to pay such dues and assessments as were levied by the board of trustees. *American Workmen v. Night*, 202 Ark. 678, 152 S.W.2d 545 (1941) (decision under prior law).

23-74-302. Amendments to laws.

(a)(1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof, or, if its laws so provide, by referendum.

(2) The referendum may be held in accordance with the provisions of its laws and by the vote of delegates or representatives of voting members or by the vote of local lodges.

(3) A society may provide for voting by mail.

(4) No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of the submission thereof, a majority of the members voting shall have signified their consent to the amendment by one (1) of the methods specified in this section.

(b)(1) No amendment to the laws of any domestic society shall take effect unless approved by the Insurance Commissioner who shall approve the amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society.

(2) Unless the commissioner disapproves any such amendment within sixty (60) days after the filing of the amendment, the amendment shall be considered approved.

(3)(A) The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office.

(B) In case the commissioner disapproves the amendment, the reasons therefor shall be stated in the written notice.

(c)(1) Within ninety (90) days from the approval thereof by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society.

(2) The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that any amendments or synopsis thereof have been duly addressed and mailed, shall be prima facie evidence that the amendments or synopsis thereof have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this state shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of the amendments of, or additions to, its laws.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

History. Acts 1989, No. 881, § 1.

CASE NOTES**Evidence.**

An amended bylaw properly certified is admissible in evidence without proof that a copy thereof had been filed in the Insur-

ance Department (now filed with the Insurance Commissioner). *Sovereign Camp, W.O.W. v. Barnes*, 154 Ark. 486, 243 S.W. 55 (1922) (decision under prior law).

23-74-303. Institutions.

A society may create, maintain, and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by § 23-74-105(a)(2). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement, but shall not be allowed as an admitted society asset. No society shall own or operate funeral homes or undertaking establishments.

History. Acts 1989, No. 881, § 1.

23-74-304. Reinsurance.

(a) By a reinsurance agreement, a domestic society may cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make the reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the Insurance Commissioner, but no such society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on the ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after January 1, 1990, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subsection (a) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under § 23-74-305.

History. Acts 1989, No. 881, § 1.

23-74-305. Consolidations and mergers.

(a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the Insurance Commissioner:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a

date fixed by the commissioner but not earlier than December 31 next preceding the date of the contract;

(3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds ($\frac{2}{3}$) vote of the supreme governing body of each society, the vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(4) Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full of the official publication of each society.

(b) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In that event, the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of the state or territory and a certificate of the approval filed with the commissioner of this state, or, if the laws of the state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of the state or territory and a certificate of the approval filed with the commissioner of this state. In case such a contract is not approved, it shall be inoperative, and the fact of the submission and its contents shall not be disclosed by the commissioner.

(c) Upon the consolidation's or merger's becoming effective as provided in this section, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action thereunto belonging, shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after the consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document stating that the notice or document has been duly addressed and mailed shall be prima facie evidence that the notice or document has been furnished the addressees.

23-74-306. Conversion of fraternal benefit society into mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of §§ 23-63-205 and 23-63-207 and other provisions of this code applicable to domestic mutual life legal reserve insurers. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds ($\frac{2}{3}$) of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such a plan. No such conversion shall take effect unless and until approved by the Insurance Commissioner, who may give such approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

History. Acts 1989, No. 881, § 1.

Meaning of "this code". Acts 1959, No. 148, codified as §§ 23-60-101 — 23-60-108, 23-60-110, 23-61-101 — 23-61-112, 23-61-201 — 23-61-206, 23-61-301 — 23-61-307, 23-61-401, 23-61-402, 23-62-101 — 23-62-108, 23-62-201, 23-62-202, former 23-62-203, 23-62-204, 23-62-205, 23-63-101 [repealed], 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, 23-63-301, 23-63-302, 23-63-401 — 23-63-404 [repealed], 23-63-601 — 23-63-604, 23-63-605 — 23-63-609 [repealed], 23-63-610 — 23-63-613, 23-63-701, 23-63-801 — 23-63-833, 23-63-835 — 23-63-838, 23-63-901 — 23-63-912, 23-63-1001 — 23-63-1004, 23-64-101 — 23-64-103, 23-64-201 — 23-64-205, 23-64-206 [repealed], 23-64-207, 23-64-208 [repealed], 23-64-209, 23-64-210, 23-64-211 — 23-64-213 [repealed], 23-64-214 — 23-64-221, 23-64-222 [repealed], 23-64-227, 23-64-228 [transferred], 23-64-229 [transferred], 23-65-101 — 23-65-104,

23-65-201 — 23-65-205, 23-65-301 — 23-65-319, 23-66-201 — 23-66-214, 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, 23-66-314, 23-68-101 — 23-68-113, 23-68-115 — 23-68-132, 23-69-101 — 23-69-103, 23-69-105 — 23-69-141, 23-69-143, 23-69-149 — 23-69-156, 23-70-101 — 23-70-124, 23-71-101 — 23-71-116, 23-72-101 — 23-72-122, 23-73-101 — 23-73-116, 23-74-101 — 23-74-141 [revised], 23-75-101 — 23-75-116, 23-75-117 [repealed], 23-75-118 — 23-75-120, 23-79-101 — 23-79-106, former 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, 23-79-202 — 23-79-210, 23-81-101 — 23-81-117, 23-81-120 — 23-81-136, 23-81-201 — 23-81-213, 23-82-101 — 23-82-118, 23-84-101 — 23-84-111, 23-85-101 — 23-85-131, 23-86-101 — 23-86-104, 23-86-106 — 23-86-109, 23-86-112, 23-87-101 — 23-87-119, 23-88-101, 23-89-101, 23-89-102, 26-57-601 — 26-57-605, 26-57-607, 26-57-608, and 26-57-610.

SUBCHAPTER 4 — CONTRACTUAL BENEFITS

SECTION.

- 23-74-401. Benefits.
- 23-74-402. Beneficiaries.
- 23-74-403. Benefits not attachable.
- 23-74-404. The benefit contract.

SECTION.

- 23-74-405. Nonforfeiture benefits, cash surrender values, certificate loans, and other options.

Effective Dates. Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the Eighty-third General Assembly that

the term disability insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national

industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Gov-

ernor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-74-401. Benefits.

(a) A society may provide the following contractual benefits in any form:

- (1) Death benefits;
- (2) Endowment benefits;
- (3) Annuity benefits;
- (4) Temporary or permanent disability benefits;
- (5) Hospital, medical, or nursing benefits;
- (6) Monument or tombstone benefits to the memory of deceased members; and

(7) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Character of Policies.

The character of policies issued by foreign fraternal benefit society, such as whole life certificates, ordinary life policies, term insurance, income policies, and endowment policies did not cause the sta-

tus of such company to be an old line life insurance company instead of a fraternal benefit society. *Modern Woodmen of Am. v. State ex rel. Attorney Gen.*, 193 Ark. 458, 103 S.W.2d 38 (1937) (decision under prior law).

23-74-402. Beneficiaries.

(a)(1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable.

(2) Through its laws or rules, a society may limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

(c) If, at the death of any member, there is no lawful beneficiary to whom the insurance benefits are payable, the amount of such benefits, except to the extent that funeral benefits may be paid as provided in subsection (b) of this section, shall be payable to the personal representative of the deceased insured. However, if the owner of the certificate is other than the insured, the proceeds shall be payable to such an owner.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Designation of Beneficiary.

Under former similar section, a change of beneficiary must be in substantial compliance with the constitution and bylaws

of the society issuing a benefit certificate. *Gibson v. Moore*, 187 Ark. 897, 63 S.W.2d 344 (1933) (decision under prior law).

23-74-403. Benefits not attachable.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any society, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Garnishment.

A fraternal benefit society is not subject to garnishment. *Acree v. Whitley*, 136 Ark.

149, 206 S.W. 137 (1918) (decision under prior law).

23-74-404. The benefit contract.

(a)(1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby.

(2) The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state.

(3) A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate.

(4) All statements on the application shall be representations and not warranties.

(5) Any waiver of this provision shall be void.

(b) Any changes, additions, or amendments to the laws of the society, duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as though such charges, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits that the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) In lieu of or in combination with subdivision (d)(1) of this section, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f)(1) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the Insurance Commissioner in the manner provided for like policies issued by life insurers in this state.

(2)(A) Every life, accident, health, or accident and health insurance certificate and every annuity certificate issued on or after January 1, 1991, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates.

(B) The certificate shall also contain a provision stating the amount of premiums that are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate that, if violated, will result in the termination or reduction of benefits payable under the certificate.

(C) If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to such a transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

History. Acts 1989, No. 881, § 1; 2001, No. 1603, § 32.

Amendments. The 2001 amendment redesignated former (f) as present (f)(1) and (f)(2) and made related changes; sub-

stituted "Insurance Commissioner" for "commissioner" in (f)(1); substituted "accident and health" for "disability" in (f)(2)(A); and made minor stylistic changes.

CASE NOTES

Designation of Beneficiary.

Under former similar section, a change of beneficiary must be in substantial compliance with the constitution and bylaws

of the society issuing a benefit certificate. *Gibson v. Moore*, 187 Ark. 897, 63 S.W.2d 344 (1933) (decision under prior law).

23-74-405. Nonforfeiture benefits, cash surrender values, certificate loans, and other options.

(a) For certificates issued prior to January 1, 1991, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to January 1, 1990.

(b) For certificates issued on or after January 1, 1991, for which reserves are computed on the Insurance Commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial table or the commissioner's 1958 standard ordinary mortality table, or the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

History. Acts 1989, No. 881, § 1.

CASE NOTES

ANALYSIS

Forfeiture of policy.
Reserve.

Forfeiture of Policy.

A fraternal benefit society could not declare a forfeiture of a member's policy for failure to pay dues when it owed the member sick benefits in an amount in excess of his dues. *Knights of Pythias of N. Am. v. Sanders*, 174 Ark. 279, 295 S.W. 25 (1927) (decision under prior law).

Reserve.

Foreign fraternal benefit society which has built up a reserve so as to make it solvent and which maintains a contingency reserve of considerable proportions did not cease to be a fraternal beneficiary society and become an old line insurance company since the statute required it to maintain a reserve. *Modern Woodmen of Am. v. State ex rel. Attorney Gen.*, 193 Ark. 458, 103 S.W.2d 38 (1937) (decision under prior law).

SUBCHAPTER 5 — FINANCIAL

SECTION.

23-74-501. Investments.
23-74-502. Funds.

SECTION.

23-74-503. Exemptions.
23-74-504. Taxation.

23-74-501. Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated shall be held to meet the requirements of this section for the investment of funds.

History. Acts 1989, No. 881, § 1.

23-74-502. Funds.

(a) All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(c)(1) Pursuant to resolution of its supreme governing body, a society may establish and operate one (1) or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts as provided in § 23-81-401 et seq.

(2) To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may:

(A) Adopt special procedures for the conduct of the business and affairs of a separate account;

(B) For persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and

(3) Issue contracts on a variable basis to which § 23-74-404(b) and (d) shall not apply.

History. Acts 1989, No. 881, § 1.

23-74-503. Exemptions.

Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the general insurance laws of this state unless they be expressly designated therein or unless it is specifically made applicable by this chapter.

History. Acts 1989, No. 881, § 1.

CASE NOTES

ANALYSIS

Filing actions.

Mutual insurance companies.

Service of process.

Filing Actions.

Where there was no clause in policy covering the matter, section relating to the time of bringing action after nonsuit applied to fraternal benefit societies. *Liebe v. Sovereign Camp, W.O.W.*, 205 Ark. 540, 170 S.W.2d 370 (1943) (decision under prior law).

Mutual Insurance Companies.

Former identical section had no application to a mutual insurance company not

coming within the definition of a fraternal benefit society. *Illinois Bankers' Life Ass'n v. Mann*, 158 Ark. 425, 250 S.W. 887 (1923) (decision under prior law).

Service of Process.

Former identical section did not exclude benefit societies from the operation of statutes regulating service upon corporations generally. *Grand Court, Order of Calanthe v. Carter*, 184 Ark. 819, 43 S.W.2d 531 (1931) (decision under prior law).

23-74-504. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from every state, county, district, municipal, and school tax other than taxes on real estate.

History. Acts 1989, No. 881, § 1.

SUBCHAPTER 6 — REGULATION

SECTION.

- 23-74-601. Valuation.
 23-74-602. Reports.
 23-74-603. Annual license.
 23-74-604. Examination of societies — No adverse publications.
 23-74-605. Foreign or alien society — Admission.
 23-74-606. Injunction, liquidation, or receivership of domestic society.

SECTION.

- 23-74-607. Suspension, revocation, or refusal of license of foreign or alien society.
 23-74-608. Injunction.
 23-74-609. Licensing of agents.
 23-74-610. Unfair methods of competition *and unfair and deceptive acts and practices.

Effective Dates. Acts 1991, No. 337, § 5: Mar. 4, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present law on the licensing of agents of fraternal benefit societies is inadequate for the protection of the public and the immediate passage of

this act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

23-74-601. Valuation.

(a) Standards of valuation for certificates issued prior to January 1, 1991, shall be those provided by the laws applicable immediately prior to January 1, 1990.

(b)(1) The minimum standards of valuation for certificates issued on or after January 1, 1991, shall be based on the following tables:

(A) For certificates of life insurance — the Insurance Commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table, or any more recent table made applicable to life insurers; and

(B) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits, and for non-cancellable accident and health benefits — such tables as are authorized for use by life insurers in this state.

(2) All of the above shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(c) In his or her discretion, the commissioner may:

(1) Accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section; and

(2) Vary the standards of mortality applicable to all benefit contracts

on substandard lives or other extra-hazardous lives by any society authorized to do business in this state.

(d) Any society, with the consent of the commissioner of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

History. Acts 1989, No. 881, § 1.

23-74-602. Reports.

(a) Reports shall be filed in accordance with the provisions of this section.

(b)(1) Every society transacting business in this state shall annually, on or before March 1, unless for cause shown such time has been extended by the Insurance Commissioner, file with the commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay any applicable fees for filing same.

(2) The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(c)(1) As part of the annual statement required by this section, each society shall file with the commissioner, on or before March 1, a valuation of its certificates in force on the immediately preceding December 31, provided that the commissioner, in his or her discretion for cause shown, may extend the time for filing the valuation for not more than two (2) calendar months.

(2) The valuation shall be done in accordance with the standards specified in § 23-74-601.

(3) The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(d) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars (\$100) for each day during which the neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while the default continues.

History. Acts 1989, No. 881, § 1.

23-74-603. Annual license.

Societies which are now authorized to transact business in this state may continue such business until April 1, 1990. The authority of such societies and all societies hereafter licensed may thereafter be renewed annually, but in all cases to terminate on the succeeding April 1. However, a license so issued shall continue in full force and effect until the new license be issued or specifically refused. For each such license

or renewal, the society shall pay the Insurance Commissioner one hundred dollars (\$100). A duly certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

History. Acts 1989, No. 881, § 1.

23-74-604. Examination of societies — No adverse publications.

(a)(1) The Insurance Commissioner, or any person he or she may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign, or alien insurers.

(2) Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined, or whose certificates are valued, upon statements furnished by the commissioner.

History. Acts 1989, No. 881, § 1.

23-74-605. Foreign or alien society — Admission.

(a) No foreign or alien society shall transact business in this state without a license issued by the Insurance Commissioner. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this state:

(1) Upon filing with the commissioner:

(A) A duly certified copy of its articles of incorporation;

(B) A copy of its bylaws, certified by its secretary or corresponding officer;

(C) A power of attorney as prescribed in § 23-74-701;

(D) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country, satisfactory to the commissioner of this state;

(E) Certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business therein;

(F) Copies of its certificate forms; and

(G) Such other information as the commissioner may deem necessary; and

(2) Upon showing that its assets are invested in accordance with the provisions of this chapter.

(b) Any foreign or alien society desiring admission to the state shall have the qualifications required of domestic societies organized under this chapter.

History. Acts 1989, No. 881, § 1; 2001, deleted “to the commissioner” following No. 1604, § 73.

Amendments. The 2001 amendment

23-74-606. Injunction, liquidation, or receivership of domestic society.

(a) When the Insurance Commissioner upon investigation finds that a domestic society:

- (1) Has exceeded its powers;
- (2) Has failed to comply with any provision of this chapter;
- (3) Is not fulfilling its contracts in good faith;
- (4) Has a membership of less than four hundred (400) after an existence of one (1) year or more; or

(5) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business, the commissioner shall notify the society of the deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After the notice, the society shall have a thirty-day period in which to comply with the commissioner’s request for correction, and if the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such a date the society does not present good and sufficient reasons why it should not be so enjoined or why such an action should not be commenced, the commissioner may present the facts relating thereto to the Attorney General who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

- (1) The commissioner finds that the violation complained of has been corrected;
- (2) The costs of such an action shall have been paid by the society if the court finds that the society was in default as charged;
- (3) The court has dissolved its injunction; and
- (4) The commissioner has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society, and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(e)(1) No action under this section shall be recognized in any court of this state unless brought by the Attorney General upon request of the commissioner.

(2) Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as the receiver.

(f) The provisions of this section relating to hearing by the commissioner, action by the Attorney General at the request of the commissioner, hearing by the court, injunction, and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

History. Acts 1989, No. 881, § 1.

CASE NOTES

Receiver.

Chancery court cannot appoint receiver of insurance company. Grand Lodge,

A.O.U.W. v. Adair, 182 Ark. 684, 32 S.W.2d 430 (1930) (decision under prior law).

23-74-607. Suspension, revocation, or refusal of license of foreign or alien society.

(a) When the Insurance Commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

- (1) Has exceeded its powers;
- (2) Has failed to comply with any of the provisions of this chapter;
- (3) Is not fulfilling its contracts in good faith; or
- (4) Is conducting its business fraudulently or in a manner hazardous

to its members or creditors or the public, the commissioner shall notify the society of the deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist be corrected. After the notice, the society shall have a thirty-day period in which to comply with the commissioner's request for correction; and if the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked, or refused. If on such a date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that the suspen-

sion or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(b) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time the society was legally authorized to transact business as provided in this chapter.

History. Acts 1989, No. 881, § 1.

23-74-608. Injunction.

No application or petition for injunction against any domestic, foreign, or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the Attorney General upon request of the Insurance Commissioner.

History. Acts 1989, No. 881, § 1.

23-74-609. Licensing of agents.

(a) Agents of societies shall be licensed in accordance with the provisions of the laws regulating the licensing, revocation, suspension, or termination of license of resident and nonresident agents, provided that:

(1) No examination shall be required to maintain or renew a license for agents of societies who held a license on December 31, 1989; and

(2) No examination shall be required to obtain a license or to renew a license thereby obtained for agents of societies applying for license on or after January 1, 1990, and before July 1, 1991.

(b) No examination or license shall be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) No examination or license shall be required of any agent or representative of a society who devotes, or intends to devote, less than fifty percent (50%) of his or her time to solicitation and procurement of insurance contracts for the society, except that any person who in the immediately preceding calendar year solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of fifty thousand dollars (\$50,000), or, in the case of any other kinds of insurance which the society writes, on the persons of more than twenty-five (25) individuals and who received or will receive a commission or other compensation therefor, is presumed to be devoting or intending to devote fifty percent (50%) of his or her time to the solicitation or procurement of insurance contracts for the society.

History. Acts 1989, No. 881, § 1; 1991, No. 337, § 1.

23-74-610. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this state shall be subject to the Trade Practices Act, § 23-66-201 et seq. However, nothing in the Trade Practices Act, § 23-66-201 et seq., shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

History. Acts 1989, No. 881, § 1.

SUBCHAPTER 7 — MISCELLANEOUS

SECTION.

23-74-701. Service of process — Registered agent.

23-74-702. Review.

23-74-703. Penalties.

SECTION.

23-74-704. Exemption of certain societies.

23-74-705. Applicability of other code provisions.

23-74-701. Service of process — Registered agent.

(a)(1) Every society authorized to do business in this state shall appoint in writing to the Insurance Commissioner an Arkansas resident as its registered agent to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such a writing that any lawful process against it that is served on the attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state.

(2) Copies of the registration, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(b) On or after January 1, 2003, service shall be made upon the registered agent listed with the commissioner in the manner provided in §§ 23-63-301 — 23-63-304, except that no service of legal process shall require a society to file its answer, pleading, or defense in less than thirty (30) calendar days after the date of service upon its registered agent in this state.

History. Acts 1989, No. 881, § 1; 2001, No. 1604, § 74.

Amendments. The 2001 amendment rewrote this section.

CASE NOTES

ANALYSIS

Appointment of commissioner.
Doing business in state.
Filing answers.

Appointment of Commissioner.

A foreign fraternal benefit society doing business in the state in violation of former identical section was estopped to deny that the insurance commissioner was its agent upon whom legal process directed against it might be served. *North Am. Union v. Johnson*, 142 Ark. 378, 219 S.W. 769 (1920) (decision under prior law).

Doing Business in State.

A foreign fraternal benefit society was held to be doing business in the state.

North Am. Union v. Oliphant, 141 Ark. 346, 217 S.W. 1 (1919) (decision under prior law).

Filing Answers.

A judgment by default rendered more than the statutory period from service of summons was not void because the summons stated that the complaint would be taken as confessed unless answered within a time shorter than the statutory period from the service of summons. *United Order of Good Samaritans v. Brooks*, 168 Ark. 570, 270 S.W. 955 (1925) (decision under prior law).

23-74-702. Review.

All decisions and findings of the Insurance Commissioner made under the provisions of this chapter shall be subject to review by proper proceedings in any court of competent jurisdiction in this state.

History. Acts 1989, No. 881, § 1.

23-74-703. Penalties.

(a) Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, upon conviction, shall be fined not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1000) or imprisoned in the county jail for not less than one (1) year, or both.

(b) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for that purpose of procuring payment of a benefit named in the certificate, is guilty of perjury and is subject to the penalties therefor prescribed by law.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state, upon conviction, shall be fined not less than fifty dollars (\$50) nor more than two hundred dollars (\$200).

(d) Any person guilty of a willful violation of, or neglect or refusal to comply with, this chapter for which a penalty is not otherwise prescribed, upon conviction, shall be subject to a fine not exceeding one thousand dollars (\$1000).

History. Acts 1989, No. 881, § 1.

23-74-704. Exemption of certain societies.

(a) Nothing contained in this chapter shall be so construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders, or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges;

(2) Orders, societies, or associations which admit to membership only persons engaged in one (1) or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(3) Domestic societies which limit their memberships to employees of a particular city or town, designated firm, business house, or corporation which provide for a death benefit of not more than four hundred dollars (\$400) or disability benefits of not more than three hundred fifty dollars (\$350) to any person in any one (1) year, or both; or

(4) Domestic societies or associations of a purely religious, charitable, or benevolent description, which provide for a death benefit of not more than four hundred dollars (\$400) or for disability benefits of not more than three hundred fifty dollars (\$350) to any person in any one (1) year, or both.

(b) Any such society or association described in subdivision (a)(3) or (4) of this section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subdivision (a)(4) of this section which has more than one thousand (1,000) members, shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof.

(c) No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in subdivision (a)(2) of this section, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits, shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter, except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such a society.

(e) The Insurance Commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from the provisions of this chapter.

(f) Societies exempted under the provisions of this section shall be exempt from all other provisions of the general insurance laws of this state.

History. Acts 1989, No. 881, § 1.

23-74-705. Applicability of other code provisions.

In addition to those contained in this chapter, the following provisions of this code shall also apply to fraternal benefit societies to the extent as applicable:

- (1) Sections 23-60-101 — 23-60-108 and 23-60-110, general provisions;
- (2) Sections 23-61-101 et seq., 23-61-201 et seq., and 23-61-301 et seq., the State Insurance Department;
- (3) Section 23-61-401, license and miscellaneous fees;
- (4) Sections 23-65-101 et seq., 23-65-201 et seq., and 23-65-301 et seq., unauthorized insurers and surplus lines;
- (5) Sections 23-68-101 — 23-68-113 and 23-68-115 — 23-68-132, rehabilitation and liquidation; and
- (6) Section 23-79-208, damages and attorney's fees on loss claims.

History. Acts 1989, No. 881, § 1.

Meaning of "this code". Acts 1959,

No. 148, codified as set out in the note following § 23-74-306.

CHAPTER 75

HOSPITAL AND MEDICAL SERVICE CORPORATIONS

SECTION.

- 23-75-101. Definition.
- 23-75-102. Applicability of other provisions.
- 23-75-103. Provisions exclusive.
- 23-75-104. Not applicable to employer plan.
- 23-75-105. Relationship of physician, patient, and hospital unaffected.
- 23-75-106. Incorporation.
- 23-75-107. Certificate of authority — Application.
- 23-75-108. Certificate of authority — Requirements for issuance.
- 23-75-109. Deposit for protection of subscribers.
- 23-75-110. Contracting authority — Fil-

SECTION.

- ing of contract.
- 23-75-111. Subscription contracts.
- 23-75-112. Directors.
- 23-75-113. Expenses and investments.
- 23-75-114. Annual report — Examination.
- 23-75-115. Use of surplus.
- 23-75-116. Nonliability.
- 23-75-117. [Repealed.]
- 23-75-118. Review of decisions.
- 23-75-119. Premium tax.
- 23-75-120. Tax exemptions.
- 23-75-121. Power to make donations for the public welfare.
- 23-75-122. Conversion to legal reserve mutual life insurer.

Cross References. Coverage of outpatient services, § 23-85-133.

Minimum policy benefits for mental illness, § 23-86-113.

Refund of unearned premiums upon death of insured, § 23-85-134.

Effective Dates. Acts 1969, No. 263, § 8: Mar. 14, 1969. Emergency clause provided: "It is hereby found and determined

by the General Assembly that there are a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical and hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be

corrected. Therefore, an emergency is declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall take effect and be enforced from and after its passage and approval."

Acts 1975, No. 404, § 8: Mar. 14, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical and hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 642, § 5: Mar. 28, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 649, § 9: Mar. 28, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical and hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1977, No. 789, § 10: Mar. 28, 1977.

Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health, and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 522, § 53: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 1123, § 25: Apr. 9, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety all provisions of this Act other than Section 22 shall be in full force and effect from and after July 1, 1991 and Section 22 shall be in full force and effect from and after the passage and approval of this Act."

Acts 1995, No. 408, § 7: Feb. 22, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the laws of this state as to taxation of hospital and/or medical service corporations are not consistent with taxation laws of similarly situated life and/or disability insurers or health maintenance organizations, and that immediate passage of this act is necessary in order to provide for the protection of the people. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health

and safety shall be in full force and effect from and after its passage and approval.”

Acts 2001, No. 580, § 29, provided: “Effective date. The effective date of the provisions of this act is July 1, 2002. However, the commissioner may extend the effective date to a subsequent date, but no later than October 31, 2002, if he finds that implementation of the act is not possible by July 1, 2002.”

Acts 2001, No. 580, § 30: Mar. 6, 2001. Emergency clause provided: “It is hereby found and determined by the Eighty-third General Assembly of the State of Arkansas that the present laws on licensure of Arkansas surplus line brokers do not meet compliance with the Gramm-Leach-Bliley Act of 1999, Public Law 106-102, 113 Stat. 1338, and that other insurance laws are inadequate to protect the public; that in pertinent part, the changes to the insurance code are needed to assure compliance with the provisions of that new federal law which do not allow discrimination in licensure of resident and nonresident applicants for insurance by state insurance regulators; that Arkansas must achieve compliance with this new Federal law which was enacted in 1999 and which has a November 12, 2002 compliance deadline in regard to the Arkansas Insurance Department’s regulation of agents, brokers, surplus line brokers, and other applicants for individual and corporate licenses; and that implementation after the effective date of this act will require significant time on the part of the industry and the

Arkansas Insurance Department to come into compliance by the November 12, 2002, deadline. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after the date of its passage and approval. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: “It is found and determined by the Eighty-third General Assembly that the term disability insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

RESEARCH REFERENCES

Am. Jur. 18B *Am. Jur. 2d*, Corp., §§ 1390, 2000, 2637, 40A *Am. Jur. 2d*, Hosp., § 4.

23-75-101. Definition.

(a) As used in this chapter, “hospital service corporations”, “medical service corporations”, and “hospital and medical service corporations” are corporations organized under the laws of this state for the purpose of establishing, maintaining, and operating nonprofit hospital service or medical service plans, or combination of plans, whereby hospital, medical, and related services may be provided by hospitals, physicians, or others with which the corporations have contracted for the purposes, to such of the public as become subscribers to the corporations under

contracts which entitle each subscriber to certain hospital or medical services or benefits, or both.

(b) This section shall not be deemed to prohibit issuance, by corporations so authorized as of immediately prior to January 1, 1960, of contracts providing for the payment of cash indemnities for hospital, medical, or related services instead of providing for hospital or medical benefits on a service basis or from issuing contracts providing for a combination of indemnity and service benefits.

History. Acts 1959, No. 148, § 672; 1963, No. 54, § 1; A.S.A. 1947, § 66-4902.

CASE NOTES

Medical Service Corporations.

Since this section limits the power of medical service corporations to providing medical service, medical service corpora-

tion did not have the authority to sell life insurance policies. *Woodyard v. Arkansas Diversified Ins. Co.*, 268 Ark. 94, 594 S.W.2d 13 (1980).

23-75-102. Applicability of other provisions.

The corporations shall also be subject to the following chapters and provisions of this code, to the extent applicable and not in conflict with the express provisions of this chapter:

(1) Sections 23-60-101 — 23-60-108, and 23-60-110, referring to scope of code;

(2) Sections 23-61-101 et seq., 23-61-201 et seq., and 23-61-301 et seq., referring to the Insurance Commissioner;

(3) Sections 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, and 23-63-301 — 23-63-304, referring to registration of registered agents for service of process;

(4) Sections 23-63-901 et seq., referring to administration of deposits;

(5) Sections 23-64-101 et seq., referring to insurance producers, agents, brokers, and adjusters;

(6) Sections 23-66-201 et seq., 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, and 23-66-314, referring to trade practices and frauds;

(7) Sections 23-63-601 et seq. and 23-84-101 — 23-84-111, referring to assets and liabilities;

(8) Sections 23-68-101 et seq., referring to rehabilitation and liquidation;

(9) Sections 23-85-101 — 23-85-131, referring to accident and health insurance policies;

(10) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108, and 23-86-109, referring to group and blanket accident and health insurance;

(11) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, referring to insurance contracts;

(12) Section 23-69-134, referring to home office and records; penalty for unlawful removal of records; and

(13) Section 23-69-156, referring to extinguishment of unused corporate charters.

History. Acts 1959, No. 148, § 690; 1971, No. 127, § 2; 1977, No. 789, § 8; 1981, No. 809, §§ 18-20; 1983, No. 522, §§ 37, 38; A.S.A. 1947, § 66-4920; Acts 2001, No. 580, § 21; 2001, No. 1454, § 2; 2001, No. 1604, § 75.

Publisher's Notes. Acts 1983, No. 522, § 51, provided, in part, that the act would be cumulative of prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Amendments. The 2001 amendment by No. 580 substituted "and 23-64-506 referring to insurance producers" for "referring to" in (5).

The 2001 amendment by No. 1454 rewrote (6).

The 2001 amendment by No. 1604 rewrote this section.

Meaning of "this code". Acts 1959, No. 148, codified as set out in the note following § 23-74-306.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-75-103. Provisions exclusive.

Hospital service corporations, medical service corporations, and hospital and medical service corporations incorporated in this state shall be governed by this chapter and shall be exempt from all other provisions of this code, except as expressly provided in this chapter. No insurance law hereafter enacted shall be deemed to apply to the corporations unless they are specifically referred to therein.

History. Acts 1959, No. 148, § 671; A.S.A. 1947, § 66-4901.

Meaning of "this code". See note to § 23-75-102.

23-75-104. Not applicable to employer plan.

(a) This chapter shall not apply to any employer operating or maintaining a hospital service plan or medical service plan, participation in which is limited to his or her employees and the employees of a parent company or subsidiary company of the employer.

(b) As used in this section, the term "employees" shall include members of the families of employees.

History. Acts 1959, No. 148, § 689; 1963, No. 54, § 6; A.S.A. 1947, § 66-4919.

23-75-105. Relationship of physician, patient, and hospital unaffected.

(a) Nothing in this chapter shall be deemed to alter the relationship of physician and patient.

(b) The corporation shall not in any way influence the subscriber in his or her free choice of hospital or physician, other than to limit its benefits to participating hospitals and physicians.

(c) Nothing in this chapter shall be deemed to abridge the right of any physician or hospital to decline patients in accordance with the standards and practices of the physician or hospital, and no such corporation shall be deemed to be engaged in the corporate practice of medicine.

History. Acts 1959, No. 148, § 684;
A.S.A. 1947, § 66-4914.

23-75-106. Incorporation.

Any corporation shall hereafter be organized under the laws of this state relating to private corporations not for pecuniary profit, insofar as the laws are not inconsistent with any of the provisions of this chapter.

History. Acts 1959, No. 148, § 673;
A.S.A. 1947, § 66-4903.

23-75-107. Certificate of authority — Application.

(a) The corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it to do so.

(b) Application for the certificate of authority shall be made on forms supplied or approved by the commissioner containing such information as he or she shall deem necessary.

(c) Each application for the certificate of authority shall be accompanied by the fee prescribed by § 23-61-401 and copies of the following documents:

- (1) Articles of incorporation;
- (2) Bylaws;
- (3) Proposed contracts between the applicant and participating hospitals and physicians, showing the terms under which service is to be furnished to subscribers;
- (4) Proposed contracts to be issued to subscribers;
- (5) A table of rates to be charged to subscribers;
- (6) Financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital and the names of each contributor and the terms of each contribution; and
- (7) A statement of the area in which the corporation proposes to operate.

History. Acts 1959, No. 148, § 674;
A.S.A. 1947, § 66-4904.

23-75-108. Certificate of authority — Requirements for issuance.

(a) The Insurance Commissioner shall issue an initial certificate of authority authorizing the applicant to issue contracts to its subscribers when it is shown to the satisfaction of the commissioner that:

(1) The applicant is established as a bona fide nonprofit hospital service corporation or medical service corporation or combination of the two;

(2) The contracts, if any, between the applicant and the participating hospitals or physicians obligate each hospital or physician executing the contracts to render service to which each subscriber may be entitled under the terms of the contracts to be issued to the subscribers;

(3) The amounts provided as working capital of the corporation are repayable, without interest, out of operating expenses;

(4) The amount of money actually available for working capital is sufficient to carry on the plan for a period of six (6) months from the date of issuance of the certificate of authority; and

(5) The applicant has secured contracts of participation from sufficient hospitals or physicians, or both, to provide ample protection for its subscribers within the area proposed to be served by the applicant.

(b) The certificate of authority shall expire or terminate and be subject to annual continuation, as provided in § 23-63-211 for insurers in general.

(c) The certificate of authority shall be subject to suspension or revocation as provided in §§ 23-63-212 — 23-63-215.

(d) An applicant under this section may provide reinsurance coverage only in the specific areas of coverage set out in the applicant's certificate of authority.

History. Acts 1959, No. 148, § 675; A.S.A. 1947, § 66-4905; Acts 2003, No. 1078, § 1.

Amendments. The 2003 amendment added (d).

CASE NOTES

Cited: *Woodyard v. Arkansas Diversified Ins. Co.*, 268 Ark. 94, 594 S.W.2d 13 (1980).

23-75-109. Deposit for protection of subscribers.

(a)(1) Corporations governed by this chapter shall at all times have on deposit through the Insurance Commissioner sums as follows:

(A) If newly formed under this chapter, the sum of fifteen thousand dollars (\$15,000); or

(B) If formed under prior law, the sum as was required under the prior law.

(2)(A) Every such corporation shall deposit through the commissioner, not later than each February 1, an amount equal to two percent (2%) of the gross subscriptions collected during the preceding

calendar year until the deposit of the corporation reaches a total of fifty thousand dollars (\$50,000).

(B) All deposits shall be held in trust for the benefit and protection of the subscribers and participating hospitals and physicians of the corporation making the deposit.

(b)(1) The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the commissioner but, with his or her approval, may be invested in bonds of the United States, of any state, of any political subdivision of any state, or state warrants, which shall be assigned to the commissioner and held as provided for original deposits.

(2)(A) With the approval of the commissioner, the securities may be exchanged for similar securities or cash of equal amount.

(B) Interest on securities so deposited shall be payable to the corporation depositing them.

(c) An unsettled final judgment, arising from transactions under its certificate of authority against such a corporation shall be a lien on the deposit prescribed by this section, subject to execution after thirty (30) days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety (90) days.

(d) Upon the liquidation or dissolution of the corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the commissioner and any other assets of the insurer shall be distributed to the holders of certificates of participation in good standing at the time proceedings for the liquidation or dissolution of the corporation were commenced, prorated according to the gross amount of subscriptions which have been paid on the certificates up to the time the proceedings were commenced.

History. Acts 1959, No. 148, § 676;
A.S.A. 1947, § 66-4906.

23-75-110. Contracting authority — Filing of contract.

(a) A corporation holding a certificate of authority under this chapter may enter into contracts with:

- (1) Licensed hospitals;
- (2) Physicians and surgeons licensed to practice in this state;
- (3) Licensed nursing homes;
- (4) Visiting nurse associations; and
- (5) Any hospital maintained and operated by the state or any political subdivision thereof or operated by any corporation, association, or individual.

(b) The contracts by any corporation holding a certificate of authority under this chapter with licensed hospitals, with physicians and surgeons duly licensed to practice in this state, with licensed nursing homes, with visiting nurse associations, and with any hospital maintained and operated by the state or any political subdivision thereof or

with any corporation, association, or individual shall be filed with the Insurance Commissioner.

History. Acts 1959, No. 148, § 677; 1963, No. 54, § 2; 1975, No. 642, § 1. A.S.A. 1947, § 66-4907.

23-75-111. Subscription contracts.

(a)(1) All rates charged by the corporation to subscribers or classes of subscribers having contracts covered by §§ 23-85-101 — 23-85-131, and the form and content of all contracts between the corporation and its subscribers, classes of subscribers, or groups of subscribers, and the certificates issued by the corporation representing their subscribers' agreements shall, at all times, be subject to the prior approval of the Insurance Commissioner.

(2) Application for approval shall be made to the commissioner in such form and shall set forth such information as the commissioner may require.

(3) Rates shall not be excessive, inadequate, or unfairly discriminatory in relation to the services offered.

(4) Upon the review at any time by the commissioner of an application, the commissioner shall, if requested by the applicant before issuing an order of disapproval hold a hearing upon not less than ten (10) days' written notice, specifying the matters to be considered at the hearing, to the corporation which makes the application, and if, after the hearing, the commissioner finds that the application or a part thereof does not meet the requirements of this code, he or she shall issue an order specifying in what respects he or she finds that it so fails. Notice thereof shall immediately be served on the applicant, either personally or by mail. Within thirty (30) days before the date of such a notice, the applicant may apply to the Pulaski County Circuit Court to show cause why the action of the commissioner should not be set aside and the application approved.

(b)(1) In any hospital service corporation contract, any medical service corporation contract, or any hospital and medical service corporation contract, whether group or individual, that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age and who is chiefly dependent upon the contract holder or certificate holder for support and maintenance, shall not terminate, but coverage shall continue so long as the contract or certificate remains in force and so long as the dependent remains in such a condition.

(2) At the request and expense of the corporation, proof of the incapacity and dependency must be furnished to the corporation by the contract or certificate holder at least thirty-one (31) days before the

child's attainment of the limiting age, and, subsequently, as may be required by the corporation, but not more frequently than annually, after the two-year period following the child's attainment of the limiting age.

(c)(1) Each contract shall plainly state the services to which the subscriber is entitled and those to which the subscriber is not entitled under the plan.

(2) As to benefits provided on a service, instead of cash indemnity basis, the contract shall constitute a direct obligation of the hospitals and physicians with which or with whom the corporation has contracted for hospital or medical services.

(3) A copy of the contract shall be delivered to the subscriber.

(d)(1) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) Each filing shall be on file for a waiting period of thirty (30) days before it becomes effective. The period may be extended by the commissioner for an additional period not to exceed thirty (30) days if the commissioner gives written notice within the waiting period to the insurer which made the filing that the commissioner needs such additional time for the consideration of the filing.

(3) Upon written application by the insurer, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof.

(4) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

History. Acts 1959, No. 148, § 678; 1969, No. 263, § 5; 1971, No. 127, § 1; 1975, No. 404, § 4; 1975, No. 642, § 2; 1975, No. 649, § 4, 8; 1979, No. 906, § 1; 1983, No. 522, § 49; A.S.A. 1947, § 66-4908; Acts 1997, No. 208, § 25.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, codified as § 22-4-408, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code Annotated of 1987."

Publisher's Notes. Acts 1975, No. 649,

§ 5, as amended by Acts 1983, No. 522, § 50, provided that any person who, prior to March 28, 1975, qualified for continued coverage past age nineteen under a disability insurance policy or medical and hospital service contract and whose coverage thereunder terminated because of failure of the insurer or corporation to request and provide an examination at the expense of the insurer or corporation to prove continuing incapacity and dependence should be reinstated and included in the coverage of the policy or contract so long as the incapacity and dependency continues.

For cumulative effect of 1983 amendment to this section, see Publisher's Notes to § 23-75-102.

Meaning of "this code". See note to § 23-75-102.

23-75-112. Directors.

The directors of a corporation shall at all times include representatives of:

(1) Administrators or trustees of hospitals which have contracted with the corporation to render hospital service to subscribers, if the corporation is a hospital service corporation or a hospital and medical service corporation;

(2) Physicians and surgeons licensed to practice in this state who have contracted with the corporation to render medical service to subscribers, if the corporation is a medical service corporation or a hospital and medical service corporation; and

(3) The general public, exclusive of hospital representatives and physicians.

History. Acts 1959, No. 148, § 679;
A.S.A. 1947, § 66-4909.

23-75-113. Expenses and investments.

(a) The operating and administrative expenses of any corporation, including, but not limited to, all costs in connection with the solicitation of subscribers to such a corporation and capital expenditures, shall not exceed:

(1) Thirty percent (30%) of paid subscriptions during the first year of operation;

(2) Twenty-five percent (25%) of paid subscriptions during the second year of operation; and

(3) Twenty percent (20%) of paid subscriptions in any year thereafter.

(b) Every corporation heretofore incorporated shall maintain unearned subscription charges and other reserves upon the same basis as that required of domestic insurance companies transacting accident and health insurance.

(c) The reserves required under this section constitute a liability of the corporation in a determination of its financial condition.

(d) The funds for any corporation shall be invested as provided for insurers under §§ 23-63-801 — 23-63-833 and 23-63-835.

History. Acts 1959, No. 148, § 680; 1963, No. 54, § 3; 1975, No. 642, § 3; A.S.A. 1947, § 66-4910; Acts 2001, No. 1603, § 33.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (b).

CASE NOTES

Cited: Woodyard v. Arkansas Diversified Ins. Co., 268 Ark. 94, 594 S.W.2d 13 (1980).

23-75-114. Annual report — Examination.

(a)(1) Not later than March 1 of each year, every corporation shall file with the Insurance Commissioner a statement sworn to by at least two (2) of its principal officers, showing its condition on the last day of the next preceding calendar year.

(2) In accordance with the specifications applicable to annual financial reports, each licensed hospital or medical service corporation shall prepare and file with the commissioner a quarterly financial report on forms and at such times as the commissioner shall prescribe. The quarterly statement shall be verified by the officers of the corporation.

(b)(1) The commissioner may appoint an examiner, deputy examiner, or other person to examine into the affairs of the corporation. The person:

(A) Shall have the power of visitation and examination;

(B) Shall have and must be given free access to all the books, papers, and documents relating to the business of the corporation; and

(C) May summon the officers, agents, or employees thereof or any other persons and require them to testify under oath concerning the affairs, transactions, and condition of the corporation.

(2) An examination shall be conducted at least every three (3) years.

(3)(A) The cost of any examination and audit shall be paid by the corporation.

(B) All costs shall be paid upon the completion of the examination.

History. Acts 1959, No. 148, § 681; substituted “Insurance Commissioner” for A.S.A. 1947, § 66-4911; Acts 2001, No. 1604, § 76. “commissioner” in (a)(1); and added (a)(2) and made related changes.

Amendments. The 2001 amendment

23-75-115. Use of surplus.

Any surplus in excess of all reserves established by the directors of the corporation and shown in the annual report of a corporation may be used by the corporation for the following purposes in the order of priority shown:

(1) To liquidate on a pro rata basis any losses incurred by hospitals, physicians, and surgeons, or other similar institutions or persons, upon the settlement of bills with the corporation in any previous years;

(2) To return the original working capital contribution to the corporation, or any part thereof, on a pro rata basis; and

(3) To reduce rates charged subscribers or to expand the services rendered to them.

History. Acts 1959, No. 148, § 682; 1963, No. 54, § 4; A.S.A. 1947, § 66-4912.

23-75-116. Nonliability.

No liability shall attach to any corporation holding a certificate of authority under this chapter by reason of the failure on the part of any hospital or physician to render service to any of its subscribers, nor for the negligence, malpractice, or other acts of hospitals or physicians.

History. Acts 1959, No. 148, § 683; A.S.A. 1947, § 66-4913.

23-75-117. [Repealed.]

Publisher's Notes. This section, concerning a limitation on salaries, was repealed by Acts 2001, No. 421, § 1. The section was derived from Acts 1959, No. 148, § 685; 1963, No. 54, § 5; 1979, No. 857, § 1; A.S.A. 1947, § 66-4915.

23-75-118. Review of decisions.

All orders of the Insurance Commissioner made pursuant to this chapter shall be subject to the provisions of §§ 23-61-101 et seq. and 23-61-201 et seq., including the right of hearing, rehearing, and appeal.

History. Acts 1959, No. 148, § 686; A.S.A. 1947, § 66-4916.

23-75-119. Premium tax.

(a) The officers of every foreign or alien corporation, and the officers of every domestic corporation, transacting business under this chapter shall, at the time of making its annual statement, file with the Insurance Commissioner a sworn statement of its net direct written premiums for the year ending December 31 next preceding from subscribers residing in this state and shall pay into the State Treasury a premium tax of two and one-half percent (2.5%) on its net direct written premiums in compliance with the provisions of § 26-57-601 et seq. as a tax for the privilege of transacting business in this state.

(b) No certificate of authority shall be renewed for any corporation until the tax is paid.

(c)(1) The tax shall be in lieu of other taxes, district or state, county or municipal, based on premiums written by the corporation in this state.

(2) No subdivision of this state may impose any license fee for the privilege of conducting business in any portion thereof.

(d) Pursuant to and subject to the conditions expressed in the provisions of § 26-57-604, the corporation is entitled to take against its premium taxes due an offset or credit for the salaries or wages of noncommissioned Arkansas employees of the corporation.

(e) Absent an extension granted by the commissioner for good cause, failure of any licensed corporation to report this net direct written premium tax or pay this net direct written premium tax, or both, shall subject the corporation to the applicable penalties of this chapter and § 26-57-601 et seq.

(f) Each hospital or medical service corporation shall have one (1) fiscal year following the reporting and payment year of a premium tax obligation to request a refund or credit for any premium tax overpayment amount, after which demands or requests for such monetary overpayment refund or credit against premium tax due shall be disallowed. Any corporation thus failing or neglecting to request the overpayment refund or credit against premium taxes due and payable to this state during the year allowable as specified in this section shall not be allowed to carry over the overpayment credit for the following year or years and shall not be entitled to an overpayment refund.

History. Acts 1959, No. 148, § 687; A.S.A. 1947, § 66-4917; Acts 1991, No. 1123, § 9; 1995, No. 408, § 1.

A.C.R.C. Notes. Acts 1995, No. 408, § 3, provided: "The provisions of this act

as to premium taxes shall apply to all premiums which are written in calendar year 1994 upon which premium tax is reported and paid in 1995 upon passage of this act."

23-75-120. Tax exemptions.

(a) Every corporation doing business pursuant to this chapter is declared to be a nonprofit and benevolent institution.

(b) The corporations are exempt from state, county, district, municipal, and school tax, including the taxes prescribed by this code, and excepting only tax on net direct written premiums under § 23-75-119 and § 26-57-601 et seq. and applicable fees prescribed by § 23-61-401 and other sections of this code, or the Insurance Commissioner's rules and regulations applicable to hospital and medical service corporations, and taxes on real and tangible personal property situated in this state.

History. Acts 1959, No. 148, § 688; A.S.A. 1947, § 66-4918; Acts 1995, No. 408, § 2.

Meaning of "this code". See note to § 23-75-102.

23-75-121. Power to make donations for the public welfare.

Hospital and medical services corporations shall have power to make donations for the public welfare or for charitable, scientific, or educational purposes, subject to such limitations, if any, as may be contained in its articles of incorporation or any amendment thereto.

History. Acts 1981, No. 508, § 1; A.S.A. 1947, § 66-4921.

23-75-122. Conversion to legal reserve mutual life insurer.

(a) A hospital and medical service corporation, as defined in § 23-75-101, may be converted to a legal reserve mutual life insurer, as defined in § 23-69-102, under a plan or procedure which shall be approved by the order of the Insurance Commissioner.

(b) The commissioner shall approve any such plan or procedure if he or she finds that the plan:

(1) Would not be contrary to law and would not be contrary to the interests of subscribers or contract holders or to the public;

(2) Has been approved by the corporation in accordance with its articles of incorporation, bylaws, and with the law;

(3) Provides for definite conditions to be fulfilled by a designated early date upon which the mutualization will be deemed effective; and

(4) Provides for the protection of all existing contractual rights of the corporation's subscribers or contract holders for medical and hospital service or case or claims for reimbursement therefor, and for the mutualizing insurer to assume, without reincorporation, all assets and liabilities of the corporation.

(c) Upon conversion, the corporation will have the minimum surplus required of legal reserve mutual life insurers.

(d) Upon completion of its conversion to a legal reserve mutual life insurer as provided in this section, the corporation shall be subject to and comply with all laws and regulations applicable to legal reserve mutual life insurers.

(e) The corporation shall have the period of time which shall be specified in the commissioner's order to complete its conversion to a legal reserve mutual life insurer.

History. Acts 1985, No. 997, §§ 1-3;
A.S.A. 1947, §§ 66-4922 — 66-4924.

CHAPTER 76

HEALTH MAINTENANCE ORGANIZATIONS

SECTION.

23-76-101. Purpose.

23-76-102. Definitions.

23-76-103. Applicability of the Arkansas Insurance Code and laws concerning hospital and medical service corporations.

23-76-104. Arkansas Insurance Code sections applicable to health maintenance organizations.

23-76-105. Penalties — Enforcement.

23-76-106. License to practice, sell, or dispense required.

23-76-107. Establishment.

23-76-108. Issuance of certificate of authority.

23-76-109. Powers.

23-76-110. Governing body.

23-76-111. Fiduciary responsibilities of director, officer, or partner.

23-76-112. Evidence of coverage and charges for health care services.

SECTION.

23-76-113. Annual report and quarterly report.

23-76-114. Information to enrollees.

23-76-115. Open enrollment.

23-76-116. Complaint system.

23-76-117. Investments.

23-76-118. Protection against insolvency.

23-76-119. Prohibited practices.

23-76-120. Regulation of agents.

23-76-121. Powers of insurers and hospital and medical service corporations.

23-76-122. Examinations.

23-76-123. Suspension or revocation of certificate of authority.

23-76-124. Rehabilitation, liquidation, or conservation of health maintenance organization.

23-76-125. Regulations.

23-76-126. Administrative proceedings.

23-76-127. Fees — Disposition of revenues.

23-76-128. Applications, filings, and reports public.

SECTION.

23-76-129. Medical information confidential — Exceptions.

23-76-130. Director of the Department of Health's authority to contract.

SECTION.

23-76-131. Tax on premiums and copayments.

23-76-132. College students.

Effective Dates. Acts 1983, No. 624, § 5: Mar. 22, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the public health and welfare of the citizens of the State of Arkansas will be benefited by allowing the citizens of this State to secure the benefits provided by vision service plans; that said vision service plans provide no risk to the consuming public; and that it is in the best interest of the people of the State of Arkansas to allow said vision service plans to operate whereby the licensed optometrist or ophthalmologist is regulated by his or her respective State board. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1985, No. 804, § 33: Apr. 3, 1985. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 264, § 4: Mar. 17, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that due to current economic conditions, budgetary constraints may limit the ability of the Department of Health to adequately provide needed services unless some license fees are increased; that it is most equitable to make this increase effective immediately upon passage of this Act. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 456, § 31: Mar. 30, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1989, No. 772, § 27: Mar. 21, 1989. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 901, § 52: Apr. 6, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present laws addressed in this omnibus Act on workers' compensation benefits and insurance licensure and other insurance regulatory issues are inadequate for the protection of the Arkansas public and immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this omnibus Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is hereby found and determined by the Gen-

eral Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1999, No. 881, § 28: Mar. 25, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly of the State of Arkansas that the present funeral preneed laws, employee leasing firm laws, and other insurance laws are inadequate to protect the public. In pertinent part, the changes to the Insurance Code needed to assure the stability of funding for the Fraud Investigation Division of the Department must be enacted in the laws of this state well before the new fiscal year beginning July 1, 1999. The changes to authorized appropriations, as well as changes to the disability (health) insurance laws on individuals to conform to the federal laws on group policies with guaranteed renewability require immediate adoption; and unless this emergency clause is adopted, this act might not be-

come effective until after the beginning of the next fiscal year. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after the date of its passage and approval. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2001, No. 1702, § 3: April 17, 2001. Emergency clause provided: "It is found and determined by the General Assembly that some providers in health maintenance organization networks are failing to comply with contractual provisions prohibiting the billing of enrollees. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

RESEARCH REFERENCES

UALR L.J. Note, Insurance — Subrogation — A Subrogation Clause in a Health Insurance Policy is Enforceable Even Though the Insured Has Not Been

Made Whole. *Higginbotham v. Arkansas Blue Cross & Blue Shield*, 312 Ark. 199 (1993), 16 UALR L.J. 475.

23-76-101. Purpose.

(a) The General Assembly determines that health maintenance organizations, when properly regulated, encourage methods of treatment and controls over the quality of care which effectively contain costs and provide for continuous health care by undertaking responsibility for the provision, availability, and accessibility of services.

(b) For this reason, and because the primary responsibility of a health maintenance organization lies in providing quality health care services on a prepaid basis without regard to the type and number of services actually rendered, rather than providing indemnification

against the cost of the services, the General Assembly finds it necessary to provide a statutory framework for the establishment and continuing regulation of health maintenance organizations which is separate from the insurance laws of this state, except as otherwise provided in this chapter.

History. Acts 1975, No. 454, § 1;
A.S.A. 1947, § 66-5201.

CASE NOTES

In General.

With full knowledge of the general provisions of the insurance code the legislature specifically excepted health mainte-

nance organizations (HMOs) from the general insurance provisions. *HMO Ark., Inc. v. Dunn*, 310 Ark. 762, 840 S.W.2d 804 (1992).

23-76-102. Definitions.

As used in this chapter:

- (1) "Commissioner" means the Insurance Commissioner;
- (2) "Domestic corporation" means any corporation organized pursuant to the Arkansas Business Corporation Act, § 4-26-101 et seq., and the Arkansas Nonprofit Corporation Act, § 4-28-201 et seq.;
- (3) "Enrollee" means an individual who has been enrolled in a health care plan;
- (4) "Evidence of coverage" means any certificate, agreement, contract, identification card, or document issued to an enrollee setting out the coverage to which the enrollee is entitled;
- (5) "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services as distinguished from mere indemnification against the cost of the services on a prepaid basis through insurance or otherwise;
- (6) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization, or services incident to the furnishing of care or hospitalization, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing, or healing human illness or injury;
- (7) "Health maintenance organization" means any person which undertakes to provide or arrange for one (1) or more health care plans;
- (8) "Health professional" means physicians, dentists, optometrists, nurses, podiatrists, pharmacists, and other individuals engaged in the delivery of health services as are or may be designated under the Health Maintenance Organization Act of 1973 or any amendment thereto or regulation adopted thereunder;
- (9) "Person" means any natural or artificial person, including, but not limited to, individuals, partnerships, associations, trusts, or corporations; and

(10) "Provider" means any person who is licensed in this state to furnish health care services as a health professional.

History. Acts 1975, No. 454, § 2; Organization Act of 1973 referred to in this section is primarily codified as 42 U.S.C. § 300e et seq.

U.S. Code. The Health Maintenance

23-76-103. Applicability of the Arkansas Insurance Code and laws concerning hospital and medical service corporations.

(a)(1) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of hospital and medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter.

(2) Subdivision (a)(1) of this section shall not apply to an insurer or hospital and medical service corporation licensed and regulated pursuant to the insurance laws or the hospital and medical service corporation laws of this state, except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) The provisions of this chapter, the Arkansas Insurance Code, and the law concerning hospital and medical service corporations, § 23-75-101 et seq., shall not be applicable to any nonprofit vision service plan corporation composed of at least fifty (50) participating licensed optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis, when each licensed optometrist or ophthalmologist is subject to the rules and regulations of the professional's respective state board, and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for, so that no element of risk is incurred by any subscriber group or person.

History. Acts 1975, No. 454, § 15; A.S.A. 1947, § 66-5215; Acts 1999, No. 881, § 10; 2001, No. 1605, § 1.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148.

Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 1999 amendment added the last sentence.

The 2001 amendment rewrote this section.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-76-104. Arkansas Insurance Code sections applicable to health maintenance organizations.

Except to the extent that the Insurance Commissioner determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render such sections clearly inappropriate, the following sections are applicable to health maintenance organizations:

- (1) Sections 23-60-101 — 23-60-108 and 23-60-110, referring to scope of the Arkansas Insurance Code;
- (2) Sections 23-61-101 et seq., 23-61-201 et seq., and 23-61-301 et seq., referring to the Insurance Commissioner;
- (3) Sections 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, general provisions, and § 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;
- (4) Section 23-63-601 et seq., referring to assets and liabilities, and §§ 23-63-901 — 23-63-912, referring to administration of deposits;
- (5) Sections 23-63-1501 et seq., referring to risk-based capital requirements;
- (6) Sections 23-64-101 et seq. and 23-64-201 et seq., referring to agents, brokers, solicitors, and adjusters;
- (7) Sections 23-66-201 et seq., 23-66-301 — 23-66-306, and 23-66-308 — 23-66-314, referring to trade practices and frauds;
- (8) Sections 23-68-101 et seq., referring to rehabilitation and liquidation;
- (9) Section 23-69-134, referring to home office and records and the penalty for unlawful removal of records;
- (10) Section 23-69-156, referring to extinguishing unused corporate charters;
- (11) Sections 23-75-104 — 23-75-105, and 23-75-116, referring to hospital and medical service corporations;
- (12) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, referring to insurance contracts;
- (13) Sections 23-85-101 — 23-85-132, 23-85-134, and 23-85-136, referring to individual accident and health insurance;
- (14) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108 — 23-86-111, 23-86-113 — 23-86-117, 23-86-119, 23-86-120, 23-86-201 et seq., 23-86-301 et seq., and 23-86-401 et seq., referring to blanket and group accident and health insurance; and
- (15) Sections 23-99-201 et seq., 23-99-301 et seq., 23-99-401 et seq., 23-99-501 et seq., 23-99-601 et seq., and 23-99-701 et seq., referring to health care providers.

History. Acts 1975, No. 454, § 25; 1983, No. 624, § 2; A.S.A. 1947, § 66-5225; Acts 1999, No. 624, § 3; 2001, No. 1605, § 2.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in

the note following § 23-74-306.

Amendments. The 1999 amendment added former (c); and made stylistic changes. The 2001 amendment rewrote this section.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

CASE NOTES

Other Provisions.

There is no doubt that the general provisions of the insurance law do not apply to health maintenance organizations (HMOs). The only insurance statutes ap-

plicable to HMOs are found in § 23-75-101 et seq., Hospital and Medical Service Corporations. *HMO Ark., Inc. v. Dunn*, 310 Ark. 762, 840 S.W.2d 804 (1992) (decision under prior law).

23-76-105. Penalties — Enforcement.

(a) In lieu of suspension or revocation of a certificate of authority under § 23-76-123, the Insurance Commissioner may levy an administration penalty in an amount not less than two hundred fifty dollars (\$250), nor more than two thousand five hundred dollars (\$2,500), if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he or she calculates to be the damages suffered by enrollees or other members of the public.

(b) Any person who willfully violates this chapter shall be guilty of a misdemeanor and may be punished by a fine not to exceed one thousand dollars (\$1,000) or by imprisonment for a period not exceeding one (1) year, or both fine and imprisonment.

(c)(1) If the commissioner or the Director of the Department of Health shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the commissioner or the director may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violations.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the commissioner or the director may deem appropriate under the circumstances.

(d)(1) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

(2) Within thirty (30) days after service of the order of cease and desist, the respondent may request a hearing on the questions of whether acts or practices in violation of this chapter have occurred. The hearings shall be conducted pursuant to the provisions of §§ 23-61-303 — 23-61-307, and judicial review shall be available as provided in § 23-66-212.

(e) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Pulaski County Circuit Court for actions of this nature.

History. Acts 1975, No. 454, § 24; A.S.A. 1947, § 66-5224; Acts 1987, No. 456, § 25.

23-76-106. License to practice, sell, or dispense required.

No person shall perform any of the services or procedures or sell or dispense any goods or devices in the field of the healing arts for which a license is required under the laws of the State of Arkansas unless the person holds a valid license authorizing him or her to perform the procedures, render the services, or sell or dispense the goods or devices.

History. Acts 1975, No. 454, § 2; A.S.A. 1947, § 66-5202.

23-76-107. Establishment.

(a)(1) Any person that meets the requirements of § 23-76-102(9) may apply to the Insurance Commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization.

(2) No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, nor solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this chapter.

(3) The corporation must have the express authority to operate a health maintenance organization contained in its articles of incorporation. Incorporation shall not be required of any entity that has been issued a certificate of authority prior to March 30, 1987.

(b)(1) Every health maintenance organization, as of July 9, 1975, shall submit an application for a certificate of authority under subsection (c) of this section within sixty (60) days of July 9, 1975.

(2) Each applicant may continue to operate until the commissioner acts upon the application.

(3) In the event that an application is denied under § 23-76-108, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract made or to be made between any providers or persons listed in subdivision (c)(3) of this section and the applicant;

(5) A statement generally describing the health maintenance organization, its health care plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, that is to be issued to employers, unions, trustees, or other organizations;

(8)(A) Financial statements showing the applicant's assets, liabilities, and sources of financial support.

(B) If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter;

(9) A financial feasibility plan that includes:

(A) Detailed enrollment projections;

(B) The methodology for determining premium rates to be charged during the first twelve (12) months of operation certified by an actuary or other qualified person;

(C) A projection of balance sheets;

(D) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year; and

(E) A statement as to the source of working capital as well as any other sources of funds;

(10)(A) On and after January 1, 2003, a power of attorney executed by the applicant, if not domiciled in this state, and filed, along with a proper fee specified by the commissioner, with the commissioner's office to register an Arkansas resident to serve as the true and lawful attorney of the applicant in and for this state upon whom may be served all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state.

(B) In the event no registered agent has been chosen, the commissioner may be served until the appointment of an Arkansas-registered agent for service of process has been entered upon the records of the commissioner;

(11) A statement or map reasonably describing the geographic areas to be served;

(12) A description of the complaint procedures to be utilized as required under § 23-76-116;

(13) A description of the procedures and programs to be implemented to meet the quality of health care requirements in § 23-76-108(a)(2);

(14) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under § 23-76-110(b);

(15) A list of the names and addresses of all providers with which the health maintenance organization has agreements; and

(16) Such other information as the commissioner may require to make the determinations required in § 23-76-108.

(d)(1) A health maintenance organization shall file a notice describing any major modification of the operation set out in the information required by subsection (c) of this section unless otherwise provided for in this chapter. The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed approved.

(2) The commissioner shall promulgate rules and regulations exempting from the filing requirements of subdivision (c)(1) of this section those items the commissioner deems unnecessary.

History. Acts 1975, No. 454, § 3; A.S.A. 1947, § 66-5203; Acts 1987, No. 456, § 22; 1993, No. 901, § 35; 2001, No. 1605, § 3.

Amendments. The 2001 amendment rewrote this section.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-76-108. Issuance of certificate of authority.

(a)(1) Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall immediately transmit

copies of the application and accompanying documents to the Director of the Department of Health.

(2) The director shall determine whether the applicant for a certificate of authority with respect to health care services to be furnished:

(A) Has demonstrated the legal qualifications and authority and potential ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability and accessibility and continuity of service;

(B) Has arrangements, established in accordance with regulations promulgated by the director for an ongoing quality of health care assurance program concerning health care processes and outcomes; and

(C) Has a procedure established in accordance with regulations of the director to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and other matters as may be reasonably required by the director.

(3)(A) Within sixty (60) days of receipt of the application for issuance of a certificate of authority, the director shall certify to the commissioner whether the proposed health maintenance organization meets the requirements of subdivision (a)(2) of this section.

(B)(i) If the director certifies that the health maintenance organization does not meet the requirements, the director shall specify in what respects it is deficient.

(ii) However, the director shall not certify that the requirements are not met unless the proposed health maintenance organization has been given an opportunity to comment on the proposed findings of deficiency.

(C) If requested by the proposed health maintenance organization, the director shall hold a hearing on his or her proposed finding of deficiency.

(b) The commissioner shall issue a certificate of authority to any person filing an application pursuant to § 23-76-107 within sixty (60) days of receipt of the certificate from the director, when the commissioner is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) The director certifies in accordance with subsection (a) of this section that the health maintenance organization's proposed plan of operation meets the requirements of subdivision (a)(2) of this section;

(3) The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(4) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees;

(5) The health care plan's arrangements for health care services and the schedule of charges for use therewith are financially sound and reasonable;

(6) Any agreements with insurers, hospitals, medical service corporations, governmental entities, or any other organizations for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan are reasonable and adequate;

(7) Agreements with providers for the provision of health care services are reasonable and adequate;

(8) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to § 23-76-110;

(9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to § 23-76-107 or by independent investigation is contrary to the public interest;

(10) Any deficiencies certified by the director have been corrected;

(11) Any deposit of cash or securities, in an amount determined to be appropriate by the commissioner pursuant to § 23-76-118, is sufficient to guarantee that the obligations to provide the promised benefits will be performed; and

(12) The applicant has paid-in capital in an amount not less than one hundred thousand dollars (\$100,000) and additional working capital or surplus funds in an amount deemed by the commissioner to be adequate in relation to the proposed plan of operation.

(c) A certificate of authority shall be denied only after compliance with the requirements of § 23-76-126.

History. Acts 1975, No. 454, § 4; 1979, No. 942, § 16; A.S.A. 1947, § 66-5204; Acts 1987, No. 456, § 23.

23-76-109. Powers.

(a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and the property as may reasonably be required for its principal office or for other purposes as may be necessary in the transaction of the business of the organization;

(2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

(3) The furnishing of health care services through providers which are under contract with the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering, in addition to basic health care services, of:

(A) Additional health care services;

(B) Indemnity benefits covering out-of-area or emergency services, and special services not provided on a direct service basis; and

(C)(i) Indemnity benefits on a point-of-service basis within such limits as may be prescribed by the Insurance Commissioner.

(ii) As used in this section, the term "point-of-service" means indemnifying or paying on behalf of an enrollee for covered health care services on a nonemergency, self-referred basis obtained from providers who are not employed by, under contract with, or otherwise affiliated with, the health maintenance organization, or services obtained from providers affiliated with the health maintenance organization without proper referrals; and

(7) The contracting with providers located out of state who are properly licensed to render medical care in the jurisdiction in which such a provider is located.

(b)(1)(A) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to each exercise of any power granted in subdivision (a)(1) or (2) of this section.

(B) The commissioner shall disapprove the exercise of power if in his or her opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations.

(C) If the commissioner does not disapprove within sixty (60) days of the filing, the exercise of power shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirement of subdivision (b)(1) of this section those activities having a de minimis effect.

History. Acts 1975, No. 454, § 5; A.S.A. 1947, § 66-5205; Acts 1995, No. 1272, § 16; 1999, No. 881, § 11.

Amendments. The 1999 amendment added (a)(7) and made a related change.

23-76-110. Governing body.

(a) The governing body of any health maintenance organization shall include at least one (1) physician, one (1) dentist, one (1) pharmacist, one (1) nurse, one (1) consumer, and one (1) enrollee.

(b) The governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

History. Acts 1975, No. 454, § 6;
A.S.A. 1947, § 66-5206.

23-76-111. Fiduciary responsibilities of director, officer, or partner.

(a) Any director, officer, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization shall be responsible for the funds in a fiduciary relationship to the enrollees.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees, officers, directors, and partners in an amount not less than two hundred fifty thousand dollars (\$250,000) for each health maintenance organization or a maximum of five million dollars (\$5,000,000) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the Insurance Commissioner.

History. Acts 1975, No. 454, § 7; A.S.A. 1947, § 66-5207; Acts 2001, No. 1605, § 4. **Amendments.** The 2001 amendment added (b) and made related changes.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

23-76-112. Evidence of coverage and charges for health care services.

(a)(1)(A) Every enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(B) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital and medical service corporation, whether by option or otherwise, the insurer or the hospital and medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Insurance Commissioner.

(3) An evidence of coverage shall contain:

(A) No provisions or statements that:

(i) Are unjust, unfair, inequitable, misleading, or deceptive;

(ii) Encourage misrepresentation; or

(iii) Are untrue, misleading, or deceptive as defined in § 23-76-119; and

(B) A clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(i) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(ii) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(iii) Where and in what manner information is available as to how services may be obtained;

(iv) The total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(v) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing and approval requirements of subdivision (a)(2) of this section unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of the laws shall apply. However, to the extent that the provisions do not apply, the requirements in subdivision (a)(3) of this section shall be applicable.

(b)(1) No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until either a copy of the schedule or the methodology for determining charges has been filed with and approved by the commissioner.

(2)(A) Either a specific schedule of charges or a methodology for determining charges shall be established in accordance with the actuarial principles for various categories of enrollees, provided that charges applicable to an individual enrollee in a group contract shall not be individually determined based on the status of the enrollee's health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory.

(B) A certification by a qualified actuary, to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(c)(1)(A) Within a reasonable period, the commissioner shall approve any form if the requirements of subsection (a) of this section are met and any schedule of charges or methodology for determining charges if the requirements of subsection (b) of this section are met.

(B) It shall be unlawful to issue the form or to use the schedule of charges or methodology for determining charges until approved.

(2)(A)(i) If the commissioner disapproves the filing, he or she shall notify the filer promptly.

(ii) In the notice, the commissioner shall specify the reasons for disapproval and the findings of fact and conclusion that support the reasons.

(B) A hearing will be granted by the commissioner within sixty (60) days after a request in writing by the person filing.

(C) If the commissioner does not disapprove any form or schedule of charges within sixty (60) days of the filing of the forms or charges, they shall be deemed approved.

(3)(A) If the commissioner disapproves any form or schedule of charges or methodology for determining charges, the commissioner's disapproval and the findings of fact and conclusions that support the commissioner's reasons shall be subject to judicial review pursuant to § 23-61-307.

(B) The review shall be upon the entire record, and the commissioner's decision shall be sustained if it is supported by the preponderance of the evidence in the record.

(d) The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

History. Acts 1975, No. 454, § 8; A.S.A. 1947, § 66-5208; Acts 2001, No. 1605, § 5.

Amendments. The 2001 amendment substituted "or the methodology for determining charges" for "or amendment thereto" in (b)(1), (c)(1)(A)-(B), and (c)(3); in

(b)(2)(A), substituted "Either a specific schedule...determining charges shall" for "The charges may" and "an individual enrollee in a group contract" for "an enrollee"; and made minor stylistic and gender neutral changes throughout.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-76-113. Annual report and quarterly report.

(a) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two (2) principal officers with the Insurance Commissioner, with a copy to the Director of the Department of Health, covering the preceding calendar year.

(b)(1) The report shall be on forms prescribed by the commissioner.

(2) For the report to be filed March 1, 2002, and annually thereafter, the annual report prescribed by the commissioner shall be the current edition, published by the National Association of Insurance Commissioners, of the "Annual Statement Blank For Health", that shall be prepared in accordance with the National Association of Insurance Commissioners' "Annual Statement Instructions For Health" and shall follow those accounting practices and procedures prescribed and published in the current edition of the National Association of Insurance Commissioners' "Accounting Practices and Procedures Manual".

(3) Each authorized health maintenance organization shall furnish all information as called for by the National Association of Insurance

Commissioners' "Annual Statement Blank For Health". Further, it shall be verified by oath or affirmation of the health maintenance organization's president or vice president and secretary or actuary.

(4) The commissioner shall furnish to each domestic health maintenance organization two (2) copies of the forms on which the annual statement is to be made.

(5) The annual report shall include:

(A) An annual audited financial report certified by an independent certified public accountant;

(B) Any material changes in the information submitted pursuant to § 23-76-107(c);

(C) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(D) A summary of information compiled pursuant to § 23-76-108 in such form as required by the director; and

(E) Any other information on an annual, quarterly, or more frequent basis as the commissioner shall prescribe, relating to the performance of the health maintenance organization, that is necessary to enable the commissioner to carry out his or her duties under this chapter.

(c) Any health maintenance organization that fails to file the annual, quarterly, or any required financial or other report when due may be subject to a penalty of one hundred dollars (\$100) for each day of delinquency in the commissioner's discretion, or unless the penalty is waived by the commissioner upon a showing of good cause by the organization.

(d)(1)(A) Beginning on and after January 1, 2000, each authorized health maintenance organization shall prepare and file with the commissioner a quarterly financial report on forms and at such times as shall be prescribed by the commissioner.

(B) For the reports to be filed January 1, 2002, and quarterly reports thereafter, the quarterly financial report shall be the current edition, published by the National Association of Insurance Commissioners, of the "Quarterly Statement Blank For Health", that shall be prepared in accordance with the National Association of Insurance Commissioners' "Quarterly Statement Instructions For Health" and shall follow those accounting procedures and practices prescribed by the National Association of Insurance Commissioners' "Accounting Practices And Procedures Manual".

(2) The quarterly statement shall be verified by the officers of the health maintenance organization as required by the current edition, published by the National Association of Insurance Commissioners, of the quarterly statement instructions as a companion to the reporting form prescribed by the commissioner.

Amendments. The 1999 amendment rewrote this section.

The 2001 amendment rewrote this section.

RESEARCH REFERENCES

UALR L.J. Survey, Insurance, 12 UALR L.J. 643.
Survey of Legislation, 2001 Arkansas

General Assembly, Insurance Law, 24 UALR L.J. 577.

23-76-114. Information to enrollees.

(a) A health maintenance organization shall make available to its subscribers a list of providers upon enrollment and re-enrollment.

(b) Every health maintenance organization shall provide within thirty (30) days to its subscribers a notice of any material change in the operation of the organization, including any major change in its provider network, that will affect them directly.

(c)(1) An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee.

(2) The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(d) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained, and a telephone number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

History. Acts 1975, No. 454, § 10; A.S.A. 1947, § 66-5210; Acts 2001, No. 1605, § 6.

Amendments. The 2001 amendment rewrote this section.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-76-115. Open enrollment.

(a)(1) After a health maintenance organization has been in operation twenty-four (24) months, it shall have an annual open enrollment period of at least one (1) month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment.

(2) A health maintenance organization may apply to the Insurance Commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services.

(3) The commissioner shall approve or deny the application within sixty (60) days of its receipt from the health maintenance organization.

(b) Health maintenance organizations providing or arranging for services on a group contract basis may limit the open enrollment provided for in subsection (a) of this section to all members of the groups covered by the contracts.

History. Acts 1975, No. 454, § 11;
A.S.A. 1947, § 66-5211.

23-76-116. Complaint system.

(a)(1) Every health maintenance organization shall establish and maintain a complaint system that has been approved by the Insurance Commissioner after consultation with the Director of the Department of Health to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

(2) Each health maintenance organization shall submit to the commissioner and the director an annual report in a form prescribed by the commissioner, after consultation with the director, that shall include:

(A) A description of the procedures of the complaint system;

(B) The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed; and

(C) The number, amount, and disposition of malpractice claims settled during the year by the health maintenance organization.

(b) The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require. Complaints involving other persons shall be referred to the persons with a copy to the commissioner.

(c) The commissioner or the director may examine the complaint system, subject to the limitation concerning medical records of individuals set forth in § 23-76-122(c).

History. Acts 1975, No. 454, § 12;
A.S.A. 1947, § 66-5212; Acts 2001, No.
1605, § 7.

Amendments. The 2001 amendment
deleted "and any of the providers used by
it" at the end of (a)(2)(C).

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

23-76-117. Investments.

With the exception of investments made in accordance with § 23-76-109(a)(1), (a)(2), and (b), the investable funds of a health maintenance organization shall be invested only in securities or other investments

permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or other securities or investments as the Insurance Commissioner may permit.

History. Acts 1975, No. 454, § 13;
A.S.A. 1947, § 66-5213.

23-76-118. Protection against insolvency.

(a) DEPOSIT REQUIREMENTS.

(1)(A) All health maintenance organizations authorized to transact business in this state shall deposit through the Insurance Commissioner securities eligible for deposit under § 23-63-903 that at all times shall have a par or market value of not less than three hundred thousand dollars (\$300,000), with the exception of limited benefit health maintenance organizations whose security deposit shall not be less than one hundred thousand dollars (\$100,000).

(B) The commissioner shall also be authorized to require a special surplus deposit for the benefit of enrollees from each health maintenance organization.

(2) All deposits made through the commissioner and held in this state shall be subject to the applicable provisions of §§ 23-63-903 — 23-63-907, 23-63-910, and 23-63-911, which refer to administration of deposits.

(3)(A)(i) A health maintenance organization, excluding limited benefit health maintenance organizations, that is in operation on August 1, 1997, shall make a deposit equal to one hundred fifty thousand dollars (\$150,000).

(ii) In the second year, the amount of the additional deposit for a health maintenance organization that is in operation August 1, 1997, shall be equal to one hundred fifty thousand dollars (\$150,000), for a total of three hundred thousand dollars (\$300,000).

(B)(i) A limited benefit health maintenance organization that is in operation on August 1, 1997, shall make a deposit equal to seventy-five thousand dollars (\$75,000).

(ii) In the second year, the amount of the additional deposit for a limited benefit health maintenance organization that is in operation on August 1, 1997, shall be equal to twenty-five thousand dollars (\$25,000) for a total of one hundred thousand dollars (\$100,000).

(4) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(5)(A) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation.

(B) The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation.

(C) If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the

provisions of the Uniform Insurers Liquidation Act, § 23-68-101 et seq.

(b)(1)(A) No participating provider or the provider's agent, trustee, or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization nor make any statement, either written or oral, to any subscriber or enrollee that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the health maintenance organization.

(B)(i) If a participating provider has a pattern or practice of violating this subsection and continues to violate this subsection after the Insurance Commissioner has issued a written warning to the participating provider, the commissioner may levy a penalty in an amount not less than one hundred fifty dollars (\$150) nor more than one thousand five hundred dollars (\$1,500).

(ii) Before imposing the penalty, the commissioner shall send a written notice to the participating provider informing the provider of the right to a hearing pursuant to §§ 23-61-303 — 23-61-307.

(2) "Participating provider" means a "provider" as defined in § 23-76-102(10) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(c) CONTINUATION OF BENEFITS. The commissioner shall require that each health maintenance organization has a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid where date of services precedes the premium paid for it;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; and

(5) Any other arrangements to assure that benefits are continued as specified in this subsection.

History. Acts 1975, No. 454, § 14; A.S.A. 1947, § 66-5214; Acts 1997, No. 958, § 1; Acts 2001, No. 1702, § 1. **Amendments.** The 2001 amendment rewrote this section.

23-76-119. Prohibited practices.

(a) No health maintenance organization, or representative thereof, may knowingly cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of this chapter:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) An enrollee may not be cancelled or nonrenewed except for the failure to pay the charge for the coverage or for such other reasons as may be promulgated by the Insurance Commissioner.

(c) **HOLD HARMLESS.**

(1) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(3)(A) No participating provider or the provider's agent, trustee, or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed to them by the health maintenance

organization nor shall they make any statement, either written or oral, to any subscriber or enrollee that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the health maintenance organization.

(B)(i) If a participating provider has a pattern or practice of violating this subsection and continues to violate this subsection after the commissioner has issued a written warning to the participating provider, the commissioner may levy a penalty in an amount not less than one hundred fifty dollars (\$150) nor more than one thousand five hundred dollars (\$1,500).

(ii) Before imposing the penalty, the commissioner shall send a written notice to the participating provider informing the provider of the right to a hearing pursuant to §§ 23-61-303 — 23-61-307.

(4) “Participating provider” means a “provider” as defined in § 23-76-102(10) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

History. Acts 1975, No. 454, § 15; **Amendments.** The 2001 amendment A.S.A. 1947, § 66-5215; Acts 2001, No. 1702, § 2. added (c).

23-76-120. Regulation of agents.

(a) After notice and hearing, the Insurance Commissioner may promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents.

(b) “Agent” means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

History. Acts 1975, No. 454, § 16; A.S.A. 1947, § 66-5216.

23-76-121. Powers of insurers and hospital and medical service corporations.

(a) An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly, or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter.

(b)(1) Notwithstanding any provision of the Hospital and Medical Service Corporations Act, § 23-75-101 et seq., an insurer or a hospital and medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

(2) The enrollees of a health maintenance organization constitute a permissible group under such laws.

(3) Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health plan.

History. Acts 1975, No. 454, § 17;
A.S.A. 1947, § 66-5217.

23-76-122. Examinations.

(a) The Insurance Commissioner may make an examination of the affairs of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than one (1) time every three (3) years.

(b) The Director of the Department of Health may make an examination concerning the quality of health care services of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than one (1) time every three (3) years.

(c)(1) Every health maintenance organization shall submit its books and records relating to the health care plan to the examinations and in every way facilitate them.

(2) For the purpose of examinations, the commissioner and the director may administer oaths to and examine the officers and agents of the health maintenance organization.

(3) Medical records of individuals and records of physicians and hospitals providing services under a contract to the health maintenance organization shall be subject to the examination.

(d) The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or the director for whom the examination is being conducted.

(e) In lieu of the examination, the commissioner or the director may accept the report of an examination made by the commissioner or director of the department of health of another state.

(f)(1) Any examination under this section that is to commence within one (1) year prior to the date a health maintenance organization shall cease to provide health care services in this state, may be reduced in scope or waived in its entirety, upon application of the health maintenance organization and approval of the commissioner.

(2) The commissioner shall consider the following in determining whether a full or partial waiver may be granted:

- (A) Claims payment history;
- (B) Consumer complaint history with the department;
- (C) Financial condition; and
- (D) Compliance with § 23-76-118.

(3) Any health maintenance organization requesting a waiver of an examination shall continue to comply with § 23-76-118 until such time as it is no longer providing health care services in this state.

History. Acts 1975, No. 454, § 18; **Amendments.** The 2001 amendment A.S.A. 1947, § 66-5218; Acts 2001, No. added (f). 1605, § 8.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

23-76-123. Suspension or revocation of certificate of authority.

(a) The Insurance Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if the commissioner finds that any of the following conditions exist:

(1) The health maintenance organization is operating in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 23-76-107, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of § 23-76-112;

(3) The health care plan does not provide or arrange for basic health care services;

(4) The Director of the Department of Health certifies to the commissioner that:

(A) The health maintenance organization does not meet the requirements of § 23-76-108(a)(2); or

(B) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under § 23-76-110;

(7) The health maintenance organization has failed to implement the complaint system required by § 23-76-116 in a manner to reasonably resolve valid complaints;

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has otherwise failed to substantially comply with this chapter.

(b) A certificate of authority shall be suspended or revoked only after compliance with the requirements of § 23-76-126.

(c) When the certificate of authority of a health maintenance organization is suspended, during the period of the suspension the health maintenance organization shall not:

(1) Enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees; and

(2) Engage in any advertising or solicitation whatsoever.

(d)(1) When the certificate of authority of a health maintenance organization is revoked, the organization shall:

(A) Proceed to wind up its affairs immediately following the effective date of the order of revocation;

(B) Conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization; and

(C) Engage in no further advertising or solicitation whatsoever.

(2) By written order, the commissioner may permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History. Acts 1975, No. 454, § 19;
A.S.A. 1947, § 66-5219.

23-76-124. Rehabilitation, liquidation, or conservation of health maintenance organization.

(a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Insurance Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies.

(b) The commissioner may apply for an order directing him or her to rehabilitate, liquidate, or conserve a health maintenance organization upon any one (1) or more grounds set out in § 23-68-107 or when in his or her opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

History. Acts 1975, No. 454, § 20;
A.S.A. 1947, § 66-5220.

23-76-125. Regulations.

(a) After notice and hearing, the Insurance Commissioner may promulgate reasonable rules and regulations, not inconsistent with existing statutes of this state, as are necessary or proper to carry out the provisions of this chapter.

(b) The rules and regulations shall be subject to review in accordance with § 23-61-307.

History. Acts 1975, No. 454, § 21;
A.S.A. 1947, § 66-5221.

23-76-126. Administrative proceedings.

(a) APPLICATION FOR A CERTIFICATE OF AUTHORITY.

(1) The public hearing referred to in § 23-76-108(a)(3)(C) shall be held within sixty (60) days after receipt by the Insurance Commissioner of the certification from the Director of the Department of Health, and at least twenty (20) days' notice thereof shall be given by the commissioner to the person filing the application.

(2) At the hearing, the person filing the application, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the courts of this state.

(3) All discovery proceedings shall be concluded not later than three (3) days prior to commencement of the public hearing.

(b) PROCEEDINGS AGAINST A CERTIFICATE OF AUTHORITY.

(1) When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the health maintenance organization and the director in writing specifically stating the grounds for suspension or revocation and fixing a time of at least twenty (20) days thereafter for a hearing on the matter.

(2)(A) The director, or his or her designated representative, shall be in attendance at the hearing and shall participate in the proceedings.

(B) The recommendation and findings of the director, with respect to matters relating to the quality of health care services provided in connection with any decision regarding suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner.

(C) After the hearing or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the director.

(c) JUDICIAL REVIEW. The action of the commissioner and the recommendation and findings of the director shall be subject to review by the

Pulaski County Circuit Court. In disposing of the issue before it, the court may affirm or reverse the order of the commissioner. The review shall be upon the entire record and the commissioner's decision shall be affirmed if it is supported by the preponderance of the evidence in the record.

(d) The provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., shall apply to proceedings under this section to the extent they are not in conflict with subsections (a) and (b) of this section.

History. Acts 1975, No. 454, § 22; 1979, No. 942, § 17; 1985, No. 804, § 18; A.S.A. 1947, § 66-5222; Acts 1987, No. 456, § 24.

Publisher's Notes. Acts 1985, No. 804, § 32, provided, in part, that the act

would be cumulative of prior laws, and that no prior law or part of a law would be deemed to be in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

23-76-127. Fees — Disposition of revenues.

(a) Every health maintenance organization subject to this chapter shall pay the Department of Health the following fees:

(1) For filing, reviewing, and issuance of all documents necessary for the issuance of the original certificate of authority, one thousand dollars (\$1,000);

(2) For annual renewal of the certificate of authority, five hundred dollars (\$500);

(3) For filing an annual statement, fifty dollars (\$50.00); and

(4) For filing amendments to documents required under § 23-76-107(c)(2), twenty-five dollars (\$25.00).

(b)(1) All fees levied and collected under this section are declared to be special revenues and shall be deposited in the State Treasury, there to be credited to the Public Health Fund.

(2) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the Department of Health is authorized to transfer all unexpended funds relative to the health maintenance organization that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

(c) Every health maintenance organization subject to this chapter shall pay to the State Insurance Department Trust Fund as special revenues the following fees:

(1) For filing and reviewing all documents necessary for issuance of an original certificate of authority, one thousand dollars (\$1,000);

(2) For issuance of the original certificate of authority, two hundred dollars (\$200);

(3) For annual renewal of the certificate of authority, one hundred dollars (\$100);

(4) For filing an annual statement, fifty dollars (\$50.00); and

(5) For filing amendments to documents required under § 23-76-107, one hundred dollars (\$100).

History. Acts 1975, No. 454, § 23; 1985, No. 804, § 13; A.S.A. 1947, § 66-5223; Acts 1987, No. 264, §§ 1, 2; 1993, No. 901, § 36.

Publisher's Notes. For cumulative effect of 1985 amendment to this section, see Publisher's Notes to § 23-76-126.

23-76-128. Applications, filings, and reports public.

All applications, filings, and reports required under this chapter shall be treated as public documents.

History. Acts 1975, No. 454, § 26; A.S.A. 1947, § 66-5226.

23-76-129. Medical information confidential — Exceptions.

(a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, upon the express consent of the enrollee or applicant, pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim of litigation between the person and the health maintenance organization wherein the data or information is pertinent.

(b) A health maintenance organization shall be entitled to claim any statutory privileges against the disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

History. Acts 1975, No. 454, § 27; A.S.A. 1947, § 66-5227.

23-76-130. Director of the Department of Health's authority to contract.

(a) In carrying out his or her obligations under §§ 23-76-108(a)(2), 23-76-122(b), and 23-76-123(a), the Director of the Department of Health may contract with qualified persons to make recommendations concerning the determinations required to be made by him or her.

(b) The recommendations may be accepted in full or in part by the director.

History. Acts 1975, No. 454, § 28; A.S.A. 1947, § 66-5228.

23-76-131. Tax on premiums and copayments.

(a)(1)(A)(i) Each health maintenance organization shall pay a tax on the premiums for coverages provided during the calendar year.

(ii) The tax shall be paid on an annual basis and on a quarterly estimate basis as prescribed by the Insurance Commissioner and reconciled at the time of filing the annual statement.

(B) The taxes due from licensed health maintenance organizations under this section shall be computed on net direct written premiums at the rate described in this section and in §§ 26-57-603 and 26-57-604.

(C)(i) Further, the premium taxes at the same rate due under this section for health maintenance organization copayments shall only be computed, reported, and paid on the copayments actually received and collected by the health maintenance organization.

(ii) Copayments paid by the patient directly to the doctor, hospital, or other medical providers shall not be subject to taxation.

(2)(A) The tax shall be paid to the Treasurer of State through the commissioner as a tax imposed for the privilege of transacting business in this state.

(B) The tax shall be computed at the rate of two and one-half percent (2½%), except as provided in subsection (b) of this section.

(3)(A) The taxes shall be paid on a quarterly estimate basis as prescribed by the commissioner and reconciled annually at the time of filing the annual statement.

(B) In his or her discretion, the commissioner may suspend or revoke the certificate of authority of any health maintenance organization that fails to pay the tax levied under this section on the date due or during any reasonable extension of time therefor which may have been expressly granted by the commissioner for good cause upon the organization's request.

(b)(1) For health maintenance organizations maintaining a home office or a regional office in this state, the tax shall be computed at the rate of two and one-half percent (2½%), except for the credit as provided in § 26-57-604. For purposes of this subsection, any office in this state shall be deemed an organization's home or regional office if the office performs substantially the following functions in this state:

(A) Underwriting;

(B) Medical;

(C) Legal;

(D) Issuance of certificates or contracts;

(E) Claims servicing, information, and service;

(F) Advertising and publications;

(G) Public relations; and

(H) Hiring, testing, and training of sales or service forces.

(2) On or before March 1 of each year, any health maintenance organization desiring to qualify an office in this state as a home or regional office shall furnish to the commissioner on forms prescribed by the commissioner proof that it is operating a home or regional office in this state.

(c) The commissioner shall deposit all taxes collected under this section in the State Treasury as general revenues.

History. Acts 1987, No. 1033, § 3; 1999, No. 881, § 12.

Publisher's Notes. Acts 1987, No. 1033, § 10, provided: "The provisions of this Act as to premium taxes shall apply to all premiums which are collected in calendar year 1987 upon which the premium

tax is reported and paid in 1988, and the provisions of this Act as to income taxes shall apply to all income years beginning on or after January 1, 1987."

Amendments. The 1999 amendment rewrote (a)(1).

23-76-132. College students.

If a health maintenance organization requires the selection or assignment of a primary care physician, the health maintenance organization shall provide an enrollee who is a student enrolled at a postsecondary institution one (1) of the following options:

(1) To select two (2) primary care physicians, one (1) located near the enrollee's domicile and one (1) located near the postsecondary institution, provided both primary care physicians have provider contracts with the health maintenance organization; or

(2) To select a primary care physician when the enrollee resides near the enrollee's domicile and then change primary care physicians when the enrollee attends the postsecondary institution, the effective date of the change to be the first of the month following notification, provided both primary care physicians have provider contracts with the health maintenance organization.

History. Acts 2001, No. 1289, § 1.

CHAPTER 77

AUTOMOBILE CLUBS OR ASSOCIATIONS

SECTION.

23-77-101. Definitions.

23-77-102. Exclusive authority of chapter.

23-77-103. Penalty.

23-77-104. Clubs and associations under authority, supervision, and control of Insurance Commissioner.

23-77-105. Authority of Insurance Commissioner to grant certificates of authority and conduct hearings.

SECTION.

23-77-106. Certificate of authority required — Application and issuance.

23-77-107. Certificate of authority — Suspension and revocation.

23-77-108. Agent or representative license required — Application and issuance.

23-77-109. Annual reports and other information.

Cross References. Bond or bond card in lieu of surrender of operator's or chauffeur's license, §§ 27-50-609 and 27-50-610.

Effective Dates. Acts 1955, No. 377, § 11: approved Mar. 24, 1955. Emergency clause provided: "It is hereby found and declared to be a fact that a great number

of persons in this state hold certificates of membership in automobile clubs and associations; that there is no law of this state adequately defining, authorizing and governing automobile clubs and associations; that as a result thereof, the interest of many persons holding certificates of membership in said clubs or associa-

tions are hereby jeopardized; that certain unscrupulous persons are, and have been, engaged in the sale of memberships in some such clubs and associations; and that the provisions of this act being necessary for the immediate preservation of the public peace, health and safety and welfare, an emergency is hereby declared to exist and this act shall take effect and be in full force from and after its passage."

Acts 1983, No. 522, § 53: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1985, No. 804, § 33: Apr. 3, 1985. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full

force and effect from after its passage and approval."

Acts 1991, No. 1123, § 25: Apr. 9, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety all provisions of this Act other than Section 22 shall be in full force and effect from and after July 1, 1991 and Section 22 shall be in full force and effect from and after the passage and approval of this Act."

Acts 1993, No. 901, § 52: Apr. 6, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present laws addressed in this omnibus Act on workers' compensation benefits and insurance licensure and other insurance regulatory issues are inadequate for the protection of the Arkansas public and immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this omnibus Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

Am. Jur. 7A *Am. Jur. 2d, Auto.*, § 189.

23-77-101. Definitions.

As used in this chapter:

(1) "Automobile club or association" means:

(A) Any person, firm, association, copartnership, corporation, company, or other organization, which undertakes for consideration paid by or on behalf of its members to defray all or a part of the expenses of the members with reference to motor club service as defined in this section or which issued a certificate which provides for the payment of the benefits to the members in services, cash, by furnishing bail, or otherwise; and

(B) Every person, firm, association, copartnership, corporation, or company which prior to March 24, 1955, has undertaken for a consideration to pay money or render services to its members, or

which has issued any form of contract or certificate or membership card which, under the terms thereof, provides for the payment in money, service, or otherwise for motor club service;

(2) "Bail bond service" means any act by an automobile club or association, the purpose of which is to furnish to, or procure for, any person accused of violation of any law of this state a cash deposit, bond, or other undertaking required by law in order that the accused might enjoy his or her personal freedom pending trial, subject to, however, the provisions of §§ 27-50-611 and 27-50-612;

(3) "Buying and selling service" means any act by an automobile club or association whereby the member of any automobile club or association is aided in any way in the purchase or sale of an automobile;

(4) "Discount service" means any act by an automobile club or association resulting in the giving of special discounts, rebates, or reductions of price on gasoline, oil, repairs, parts, accessories, or service for motor vehicles to members of any automobile club or association;

(5) "Emergency road service" means any act by an automobile club or association consisting of the adjustment, repair, or replacement of the equipment, tires, or mechanical parts of an automobile so as to permit it to be operated under its own power;

(6) "Financial service" means any act by an automobile club or association whereby loans or other advances of money, with or without security, are made to members of any automobile club or association;

(7) "Insurance service" means any act by an automobile club or association consisting of the selling or giving with a membership certificate or as a result of membership in or affiliation with an automobile club or association a policy of insurance covering liability or loss by the member of any such automobile club or association as the result of injury to the person of such a member following an accident resulting from the ownership, maintenance, operation, or use of a motor vehicle;

(8) "Legal service" means any act by an automobile club or association consisting of the hiring, retaining, engaging, or appointing of an attorney or other person to give professional advice to, or represent, a member of any automobile club or association, in any court, as the result of liability incurred by the right of action accruing to the member as a result of the ownership, operation, use, or maintenance of a motor vehicle;

(9) "Map service" means any act by an automobile club or association by which road maps are furnished without cost to members of any automobile club or association;

(10) "Motor club service" means the rendering, furnishing, or procuring of four (4) or more of the following services:

- (A) Bail bond service;
- (B) Buying and selling service;
- (C) Discount service;
- (D) Emergency road service;
- (E) Financial service;

- (F) Insurance service;
- (G) Legal service;
- (H) Map service;
- (I) Theft service;
- (J) Touring service; and
- (K) Towing service;

(11) "Theft service" means any act by an automobile club or association, the purpose of which is to locate, identify, or recover a motor vehicle, owned or controlled by a member of any automobile club or association, which has been, or may be, stolen, or to detect or apprehend the person guilty of such theft;

(12) "Touring service" means any act by an automobile club or association by which touring information is furnished without cost to members of any automobile club or association or the making of arrangements, reservations for lodging or travel space, or procurement of tickets or permits for travel to any place in the world for a member of any automobile club or association; and

(13) "Towing service" means any act by an automobile club or association consisting of the drafting or moving of a motor vehicle from one (1) place to another under other than its own power.

History. Acts 1955, No. 377, §§ 1, 2; 1981, No. 821, § 1; 1985, No. 804, § 30; A.S.A. 1947, §§ 75-1601, 75-1602.

Publisher's Notes. Acts 1985, No. 804, § 32, provided, in part, that the act would be cumulative of prior laws, and

that no prior law or part of a law would be deemed to be in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

CASE NOTES

Insurance Service.

Memberships in automobile motor club whereby the club undertakes for a pecuniary consideration to indemnify the member or pay a specified amount or

provide designated benefits upon determinable contingencies come within the definition of insurance. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

23-77-102. Exclusive authority of chapter.

(a) This chapter shall be deemed and held exclusive authority for the organization and operation of automobile clubs and associations within this state, and the clubs and associations shall not be subject to any other laws respecting insurance companies of any class, kind, or character, except as to the conduct of hearings by the Insurance Commissioner and appeals therefrom.

(b) However, this chapter shall not affect the validity of any membership certificate of any automobile club or association issued and outstanding prior to March 24, 1955.

History. Acts 1955, No. 377, § 8; A.S.A. 1947, § 75-1608.

23-77-103. Penalty.

(a) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for an automobile club or association, or offer any of the motor club services as defined in § 23-77-101, except in the manner provided in this chapter and under the rules and regulations promulgated by the Insurance Commissioner.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than two hundred fifty dollars (\$250) or imprisoned not more than six (6) months, or both fined and imprisoned.

History. Acts 1955, No. 377, § 7;
A.S.A. 1947, § 75-1607.

23-77-104. Clubs and associations under authority, supervision, and control of Insurance Commissioner.

All automobile clubs and associations organized and operating in the State of Arkansas shall be under the authority, supervision, and control of the Insurance Commissioner.

History. Acts 1955, No. 377, § 4;
A.S.A. 1947, § 75-1604.

CASE NOTES**Membership Salesmen.**

The fact that this section together with §§ 23-77-105, 23-77-106, 23-77-108 and 23-77-109 place motor clubs under the supervision and regulation of the Insurance Commissioner does not of itself constitute the membership salesmen of such

clubs insurance agents or solicitors, but is a pertinent circumstance to be considered in determining the status of such salesmen. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

23-77-105. Authority of Insurance Commissioner to grant certificates of authority and conduct hearings.

(a)(1) The Insurance Commissioner shall have full and complete authority to grant certificates of authorization to automobile clubs and associations, to revoke the certificates, and to prescribe such rules and regulations as are reasonably necessary for the conduct of the business of the clubs and associations within the state and for carrying out the objects and purposes of this chapter.

(2) In determining if a certificate of authorization shall be issued, the commissioner shall take into consideration, along with all other factors, the name of the automobile club or association. If the name will interfere with the transactions of an automobile club or association already doing business in this state or is so similar to one already

appropriated as to confuse or likely to mislead the public in any respect, the commissioner shall refuse to issue a certificate of authorization.

(b) The commissioner shall also have authority to conduct hearings as now provided under the insurance laws of the state.

History. Acts 1955, No. 377, § 3;
A.S.A. 1947, § 75-1603.

CASE NOTES

Membership Salesmen.

The fact that this section together with §§ 23-77-104, 23-77-106, 23-77-108 and 23-77-109 place motor clubs under the supervision and regulation of the Insurance Commissioner does not of itself constitute the membership salesmen of such

clubs insurance agents or solicitors, but is a pertinent circumstance to be considered in determining the status of such salesmen. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

23-77-106. Certificate of authority required — Application and issuance.

(a) Every club or association desiring to commence operations within the state shall file, prior to the commencement of operations, applications with and receive a certificate of authority from the Insurance Commissioner.

(b)(1) No foreign or alien automobile club or association shall be authorized to operate in Arkansas that has not furnished the commissioner with evidence that it has been organized and actively engaged in the automobile club or association business in the state of its incorporation for a period of three (3) years prior to the date of its application to be admitted and authorized to do business in the State of Arkansas.

(2) However, this subsection shall not apply to a foreign or alien automobile club or association that is:

(A) The wholly owned subsidiary of an automobile club or association or an insurance company admitted and authorized to do business in the State of Arkansas; or

(B) The continuing corporation resulting from a merger or consolidation of automobile clubs or associations or insurance companies, at least one (1) of which is in good standing in its state or country of domicile and has been organized and actively engaged in the automobile club or association business in the state or country of domicile for at least three (3) years prior to the date of the application of that corporation to be admitted and authorized to do business in the State of Arkansas.

(3) The commissioner may accept evidence of the applicant's good standing and operation for three (3) years under licensure in its state or country of domicile or under licensure in another state or port of entry state, so long as the laws of that jurisdiction regulating automobile clubs or associations are substantially similar to the laws of this state, with forms and certifications as are specified.

(c) An automobile club or association must pay to the commissioner one hundred dollars (\$100) as an annual license fee. The license fee shall be paid to the commissioner on or before April 1 of each year.

(d)(1) The following documents and information shall be filed with the application of all automobile clubs and associations:

(A) Certification that upon full licensure it shall deposit the sum of twenty thousand dollars (\$20,000) in cash or securities as approved by the commissioner and having at all times a market value of not less than twenty thousand dollars (\$20,000);

(B) On or after January 1, 2003, appointment of an agent, including the agent's name and address, for service of process who shall be a resident of the State of Arkansas and who shall be registered with the commissioner pursuant to the provisions of §§ 23-63-301 — 23-63-304. In the event no registered agent has been listed, the commissioner may be served until the appointment of an Arkansas-registered agent for service of process has been entered upon the records of the commissioner;

(C) A copy of the proposed form of membership application, membership certificate, articles of incorporation or organization or partnership agreement, bylaws, contracts for service, advertising material, and any other data requested by the commissioner;

(D) References as to the character, ability, and integrity of the organizers, manager, agent, and any other person through whom the applicant proposes to issue contracts, membership certificates, membership cards, or other documents in return for membership fees or dues; and

(E)(i) A full and true statement of its financial condition, transactions, and affairs as of the December 31 next preceding the date of the application. The statement shall be on a calendar-year basis. The statement shall be verified by oath of two (2) officers or directors of the automobile club or association, one (1) of whom shall be its president, vice president, or secretary.

(ii) Financial statements that are consolidated with other affiliates or subsidiaries of the applicant are not acceptable, except for good cause and subsequent approval by the commissioner.

(iii) Beginning after December 31, 2002, each applicant shall file an audited financial statement for three (3) calendar years prior to the date of its application in this state.

(2) If the commissioner is satisfied that the applicant is qualified and meets all the requirements of this chapter, he or she shall issue to the applicant a certificate of authority to conduct the business of the automobile club or association within this state.

History. Acts 1955, No. 377, § 5; 1981, No. 821, § 3; 1983, No. 522, § 44; 1985, No. 804, § 2; A.S.A. 1947, § 75-1605; Acts 2001, No. 1555, § 12; 2001, No. 1604, § 77.

Publisher's Notes. Acts 1983, No. 522,

§ 51, provided, in part, that the act would be cumulative of prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

For cumulative effect of 1985 amendment to this section, see Publisher's Notes to § 23-77-101.

Amendments. The 2001 amendment by No. 1555 rewrote the section.

The 2001 amendment by No. 1604, in (d)(1)(B), substituted "On or after January

1, 2003, appointment of" for "Appointment of," inserted "including the agent's name and address," substituted "and who shall be registered with" for "or, in lieu thereof," and added "pursuant to the provisions ...of the commissioner."

CASE NOTES

Membership Salesmen.

The fact that this section together with §§ 23-77-104, 23-77-105, 23-77-108 and 23-77-109 place motor clubs under the supervision and regulation of the Insurance Commissioner does not of itself constitute the membership salesmen of such

clubs insurance agents or solicitors, but is a pertinent circumstance to be considered in determining the status of such salesmen. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

23-77-107. Certificate of authority — Suspension and revocation.

(a) The Insurance Commissioner shall suspend or revoke the certificate of authority of an automobile club or association:

(1) If the action is required by any provision of this section or §§ 23-77-101, 23-77-106, or 23-77-108;

(2) If the automobile club or association no longer meets the requirements for the authority originally granted due to a deficiency in the deposit required by § 23-77-106(d)(1)(A) or the failure to maintain a surety bond in such amount as prescribed by § 23-77-106(d)(1)(A); or

(3) If the automobile club or association is using such methods or practices in the conduct of its business as to render its further operation in Arkansas hazardous or injurious to the public.

(b) The commissioner shall give the automobile club or association at least ten (10) days' written notice in advance of any suspension or revocation under this section.

(c) The automobile club or association may request a hearing thereon within the ten (10) days.

History. Acts 1955, No. 377, § 12, as added by Acts 1981, No. 821, § 4; A.S.A. 1947, § 75-1605.1.

23-77-108. Agent or representative license required — Application and issuance.

(a) Before any agent or representative shall or may represent any automobile club or association in this state, he or she shall first apply to the Insurance Commissioner for a license, and the commissioner shall have full power and authority to issue the license upon proof satisfactory to the commissioner that the person is capable of soliciting automobile club or association memberships and is of good moral character and recommended by the club or association in behalf of which the membership solicitations are to be made.

(b) No license shall be issued by the commissioner until the applicant has paid to the commissioner ten dollars (\$10.00) as an annual license fee.

(c) The commissioner may reject the application of any person who does not meet the requirements set out in this section.

History. Acts 1955, No. 377, § 6; 1981, No. 821, § 2; A.S.A. 1947, § 75-1606; Acts 1991, No. 1123, § 10.

CASE NOTES

Membership Salesmen.

The fact that this section together with §§ 23-77-104 — 23-77-106 and 23-77-109 place motor clubs under the supervision and regulation of the Insurance Commissioner does not of itself constitute the membership salesmen of such clubs insur-

ance agents or solicitors, but is a pertinent circumstance to be considered in determining the status of such salesmen. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

23-77-109. Annual reports and other information.

(a) Each licensed automobile club or association shall annually on or before April 1, or within any extension of time therefor which the Insurance Commissioner for good cause may have granted, file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the December 31 preceding. The statement shall be in a general form and context as required or not disapproved by the commissioner.

(b) It shall be the duty of each licensed automobile club or association to provide any other information which the commissioner may request from time to time.

History. Acts 1955, No. 377, § 5; 1985, No. 804, § 28; A.S.A. 1947, § 75-1605; Acts 1993, No. 901, § 38.

Publisher's Notes. For cumulative effect of 1985 amendment to this section, see Publisher's Notes to § 23-77-101.

CASE NOTES

Membership Salesmen.

The fact that this section together with §§ 23-77-104 — 23-77-106 and 23-77-108 place motor clubs under the supervision and regulation of the Insurance Commissioner does not of itself constitute the membership salesmen of such clubs insur-

ance agents or solicitors, but is a pertinent circumstance to be considered in determining the status of such salesmen. *Arkansas Motor Club, Inc. v. Arkansas Emp. Sec. Div.*, 237 Ark. 419, 373 S.W.2d 404 (1963).

CHAPTER 78

BURIAL ASSOCIATIONS

SECTION.

23-78-101. Definitions.

SECTION.

23-78-102. Applicability.

SECTION.

- 23-78-103. Chapter exclusive authority.
- 23-78-104. Penalty.
- 23-78-105. Burial Association Board — Creation — Members.
- 23-78-106. Burial Association Board — Proceedings.
- 23-78-107. Burial Association Board — Office and employees.
- 23-78-108. Burial Association Board — Powers and duties.
- 23-78-109. Burial associations under authority, supervision, and control of board.
- 23-78-110. Certificate of authority.
- 23-78-111. Fees — Oath at payment.
- 23-78-112. Certificate for benefits — Issuance.
- 23-78-113. Agent's license required.
- 23-78-114. False claim, promise, or representation of agent.
- 23-78-115. Rules and bylaws.

SECTION.

- 23-78-116. Membership dues and assessments.
- 23-78-117. Books, records, accounts, and documents — Inspection and audit.
- 23-78-118. Books — False entries prohibited.
- 23-78-119. Records — Failure to maintain.
- 23-78-120. Semiannual reports.
- 23-78-121. Rules and regulations.
- 23-78-122. Disposition of collections.
- 23-78-123. Disposition of fees and charges.
- 23-78-124. Revocation of certificate, license, charter, etc. — Hearing.
- 23-78-125. Revocation of certificate, license, charter, etc. — Appeal.

Effective Dates. Acts 1953, No. 91, § 27: approved Feb. 18, 1953. Emergency clause provided: "It is hereby found and declared to be a fact that a great number of persons in this State hold certificates of membership in burial associations; that there is no law of this State adequately defining, authorizing and governing burial associations; that as a result thereof, the interests of many persons holding certificates of membership in said associations are thereby jeopardized; and that the provisions of this act being necessary for the immediate preservation of the public peace, health, safety and welfare, an emergency is hereby declared to exist, and this act shall take effect and be in full force from and after its passage."

Acts 1957, No. 403, § 3: Mar. 27, 1957. Emergency clause provided: "It has been found and is declared by the General Assembly of Arkansas that great need exists in the Arkansas Burial Association Board for fixing the number of officials and employees of said board, and to provide for the payment of their salaries and expenses, and that enactment of this bill will remedy this need; therefore an emergency is declared to exist, and this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in force from the date of its approval."

Acts 1961, No. 84, § 2: Feb. 13, 1961. Emergency clause provided: "It has been found and is declared by the General Assembly of Arkansas that great need exists in the Arkansas Burial Association Board for fixing the number of officials and employees of said Board, and to provide for the payment of their salaries and expenses, and that enactment of this bill will remedy this need; therefore an emergency is declared to exist, and this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in force from the date of its approval."

Acts 1973, No. 515, § 3: Mar. 30, 1973. Emergency clause provided: "It is hereby found and determined by the General Assembly that the present law relative to authorized investments of funds of burial associations and burial societies is in need of clarification with regard to the circumstances under which funds may be invested in savings and loan associations, and in other respects; and that the authorized investments of funds of burial associations and societies in this state should be liberalized immediately, while still maintaining equitable opportunities for different kinds of financial institutions to receive such investments, in order to correct this situation. Therefore, an emergency is hereby declared to exist, and this

Act, being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 717, § 3: Mar. 25, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that regulatory boards and commissions covered by Act 113 of 1977, exist for the singular purpose of protecting the public health and welfare; that it is necessary and proper that the public be represented on such boards and commissions; that the operations of such boards and commissions have a profound effect on the daily lives of all Arkansans; and that the public's voice should not be muted on any question coming before such public bodies. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health, and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 131, § 6 and No. 135, § 6: Feb. 10, 1983. Emergency clauses provided: "It is hereby found and determined by the General Assembly that state boards and commissions exist for the singular purpose of protecting the public health and welfare; that citizens over 60 years of age represent a significant percentage of the population; that it is necessary and proper that the older population be represented on such boards and commissions; that the operations of the boards

and commissions have a profound effect on the daily lives of older Arkansans; and that the public voice of older citizens should not be muted as to questions coming before such bodies. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1997, No. 250, § 258: Feb. 24, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that Act 1211 of 1995 established the procedure for all state boards and commissions to follow regarding reimbursement of expenses and stipends for board members; that this act amends various sections of the Arkansas Code which are in conflict with the Act 1211 of 1995; and that until this cleanup act becomes effective conflicting laws will exist. Therefore an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-78-101. Definitions.

As used in this chapter:

(1) "Association" or "burial association" means:

(A) Any person, firm, association, copartnership, corporation, company, or other organization which, from and after February 18, 1953:

(i) Undertakes for consideration paid by or on behalf of its members to defray all or a part of the funeral expenses of the members;

(ii) Furnishes or undertakes to furnish merchandise, supplies, and services or any other character of burial benefits to the members; or

(iii) Issues a certificate which provides for the payment of funeral benefits to the members in services, merchandise, or supplies, including the services of funeral directors and embalmers; and

(B) Every person, firm, association, copartnership, corporation, or company which, prior to February 18, 1953, has:

(i) Undertaken for a consideration to pay money to its contributors for the purposes of defraying all or part of the funeral expenses of a deceased person;

(ii) Furnished or has undertaken to furnish supplies and services or any other character of burial benefits to the contributing person or to his or her beneficiaries or members of his or her family; or

(iii) Issued any form of contract or certificate which, under its terms, provides for the payment of funeral benefits in money, services, or supplies, including the services of undertakers or embalmers; and

(2) "Board" means Burial Association Board.

History. Acts 1953, No. 91, §§ 1, 2; 1985, No. 679, § 1; A.S.A. 1947, §§ 66-1801, 66-1802.

CASE NOTES

Cited: E.H. Crump & Co. v. Gatewood, (1989); Arkansas Burial Ass'n Bd. v. 497 F. Supp. 549 (E.D. Ark. 1980); McEuen Burial Ass'n, 302 Ark. 133, 788 S.W.2d 234 (1990).
McEuen Burial Ass'n v. Arkansas Burial Ass'n Bd., 298 Ark. 572, 769 S.W.2d 415

23-78-102. Applicability.

(a) All burial associations organized or operating in the State of Arkansas as of February 18, 1953, shall be deemed in all respects to be organized or operating exclusively under the provisions of this chapter, and to have authority from the Burial Association Board to engage in their business. They shall be subject to the supervision, authority, and control of the board and subject to all the provisions of this chapter.

(b) All burial associations organized in this state from and after February 18, 1953, shall organize exclusively under the provisions of this chapter and shall be subject to the authority, control, and supervision of the board and to all of the provisions of this chapter.

History. Acts 1953, No. 91, § 7; A.S.A. 1947, § 66-1807.

23-78-103. Chapter exclusive authority.

(a) This chapter shall be deemed and held exclusive authority for the organization and operation of burial associations within this state, and the associations shall not be subject to any other laws respecting insurance companies of any class, kind, or character.

(b) However, this chapter shall not affect the validity of any membership certificate of any burial association issued and outstanding under the provisions of any prior law.

History. Acts 1953, No. 91, § 22; A.S.A. 1947, § 66-1822.

CASE NOTES

Cited: Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n, 302 Ark. 133, 788 S.W.2d 234 (1990).

23-78-104. Penalty.

(a) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for a burial association, or for participation in any plan, scheme, or device similar to burial associations, except in the manner provided by this chapter and the rules and regulations promulgated by the Burial Association Board.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than two hundred fifty dollars (\$250) or imprisoned not more than six (6) months, or both.

History. Acts 1953, No. 91, § 16; A.S.A. 1947, § 66-1816.

23-78-105. Burial Association Board — Creation — Members.

(a) There is created a Burial Association Board consisting of the following members who shall be appointed by the Governor subject to confirmation by the Senate:

(1) One (1) member from each congressional district;

(2) Three (3) at-large members;

(3) One (1) consumer representative appointed from the state at large;

(4) One (1) representative of the elderly appointed from the state at large; and

(5) Any other members who, from time to time, may be added by statute.

(b)(1)(A) The members of the board shall be:

(i) Residents of the State of Arkansas;

(ii) At least twenty-one (21) years of age; and

(iii) Of good moral character.

(B) The representative of the elderly shall be sixty (60) years of age or older.

(2)(A) Members other than the consumer representative and the representative of the elderly shall be engaged in or connected with the operation of a burial association for at least five (5) years.

(B) The consumer representative and the representative of the elderly shall not be actively engaged in or retired from the business of operating a burial association.

(3) The consumer representative position and the representative of the elderly position cannot be filled by the same person.

(c)(1) Members other than the consumer representative and the representative of the elderly shall be appointed as follows:

(A) During December of each year, the Arkansas Club of Burial Associations or its successor shall submit to the Governor a list containing the names of not fewer than two (2) qualified persons from each congressional district from which the current members' terms expire. However, at-large members may be from any congressional district, and no more than one (1) at-large member may be appointed from any one (1) congressional district;

(B) The Arkansas Club of Burial Associations shall also establish a system of rotating the at-large members to ensure equitable representation of congressional districts by the at-large members; and

(C) After receipt of the list by the Governor, the Governor shall appoint to the board one (1) member from each congressional district from which the current member's term expires, plus members from the state at large, provided the at-large member's term also expires.

(2) The requirement of appointment from a list submitted by the Arkansas Club of Burial Associations shall not be applicable to the consumer representative and the representative of the elderly.

(d)(1) The term of office shall be for three (3) years, and no member shall be appointed to more than two (2) consecutive terms upon the board.

(2) Each member shall hold office until a successor is appointed and qualified.

(e)(1) Vacancies on the board shall be filled for the unexpired term thereof by appointment by the Governor.

(2) Vacancies in positions other than those of the consumer representative and the representative of the elderly shall be filled from new lists submitted for the filling of the vacancies in the same manner provided for the appointment of those members to the board.

(f) The Governor shall have the right to remove any member of the board for gross neglect or malfeasance after notice and hearing.

(g) Before entering upon the duties of the office, the members of the board shall take the oath prescribed by the Constitution of the State of Arkansas for state officers and shall file it in the office of the Secretary of State. The Secretary of State shall thereupon issue to the person so appointed a certificate of the appointment.

(h) The members of the board may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.

History. Acts 1953, No. 91, §§ 2-4; 1965, No. 83, § 1; 1977, No. 113, §§ 1-3; 1981, No. 360, § 1; 1981, No. 717, § 2; 1983, No. 131, §§ 1-3, 5; 1983, No. 135, §§ 1-3, 5; 1983, No. 784, § 1; 1985, No. 679, §§ 1, 2; A.S.A. 1947, §§ 6-617 — 6-619, 6-623 — 6-626, 66-1802 — 66-1804; Acts 1997, No. 250, § 223; 2001, No. 1553, § 50.

Publisher's Notes. Acts 1981, No. 717, § 1, provided that the purpose of the act was to provide consumer representatives on state boards and commissions affected by Acts 1977, No. 113, full voting authority as board members.

Amendments. The 2001 amendment rewrote this section.

CASE NOTES

Cited: Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n, 302 Ark. 133, 788 S.W.2d 234 (1990).

23-78-106. Burial Association Board — Proceedings.

(a)(1) The members of the Burial Association Board shall first meet within five (5) days subsequent to their appointment and elect one (1) of their members as chair.

(2) The board shall meet thereafter at such times and at such places as may be prescribed by rules and regulations adopted by the board.

(b)(1) A simple majority of members of the board shall constitute a quorum, and the concurring votes of not less than a majority of the members present at any meeting shall be necessary to the decision of any question or issue or the authorization of any action.

(2) The consumer representative and the representative of the elderly shall be full voting members.

History. Acts 1953, No. 91, § 4; 1965, No. 83, § 1; 1977, No. 113, § 2; 1981, No. 360, § 1; 1981, No. 717, § 2; 1983, No. 131, § 3; 1983, No. 135, § 3; 1983, No. 784, § 1; 1985, No. 679, § 2; A.S.A. 1947, §§ 6-618, 6-625, 66-1804.

Publisher's Notes. As to the purpose of Acts 1981, No. 717, see Publisher's Notes to § 23-78-105.

23-78-107. Burial Association Board — Office and employees.

(a)(1) The Burial Association Board shall rent or otherwise acquire suitable quarters for an office and employ and fix the duties and the salaries of an executive secretary, two (2) auditors, and such other clerical assistance as may be necessary to carry out the provisions of this chapter.

(2) The Executive Secretary of the Burial Association Board shall furnish to the board, at the expense of the board, bond with approved corporate surety in the amount of ten thousand dollars (\$10,000), conditioned for his or her faithful application of all funds coming into his or her hands by virtue of his or her office.

(3) The board may, if it deems advisable, require other employees to make a good and sufficient corporate bond to the board at the expense of the board in such amount as the board shall determine for the faithful performance of their duties.

(b) Legal counsel shall be furnished by the office of the Attorney General.

(c) There is established for the board the maximum number of employees necessary for the maintenance and operation of the board and the maximum rates of salaries for the employees. The board is authorized to make payment for salaries, services, and other purposes from the funds received by the board.

(d) The board is authorized to make reimbursement of the necessary and reasonable travel, board, and lodging expenses of the executive secretary and auditors incurred in the performance of their duties.

History. Acts 1953, No. 91, § 4; 1957, No. 403, §§ 1, 2; 1961, No. 84, § 1; 1965, No. 83, § 1; 1981, No. 360, § 1; 1983, No. 784, § 1; 1985, No. 679, § 2; A.S.A. 1947, §§ 66-1804 — 66-1804.2.

A.C.R.C. Notes. The operation of subdivisions (a)(1) and (2) of this section was

suspended by adoption of a self-insured fidelity bond program for public officers and employees, effective July 20, 1987, pursuant to § 21-2-701 et seq. Subdivisions (a)(1) and (2) may again become effective upon cessation of coverage under that program. See § 21-2-703.

CASE NOTES

Auditor.

The position of auditor for Burial Association Board was not a “civil office” within the meaning of Ark. Const., Art. 5,

§ 10, so as to prevent the appointment of a state senator to such position. *Haynes v. Riales*, 226 Ark. 370, 290 S.W.2d 7 (1956).

23-78-108. Burial Association Board — Powers and duties.

(a) The Burial Association Board appointed pursuant to this chapter shall have full and complete authority to:

- (1) Grant certificates of authority to burial associations;
- (2) Revoke certificates of authority, charters, or other authority granted to burial associations in this state;
- (3) Fix the minimum assessments or minimum membership dues for which burial associations may issue certificates for benefits in specified amounts;
- (4) Supervise the affairs of all burial associations organized or operating in this state;
- (5) Conduct hearings as provided in this chapter and collect, receive, hold, and expend annual license fees as provided in this chapter;
- (6) Adopt and enforce such rules and regulations as it may deem necessary and expedient for the proper operation of the board and the carrying out of the objects and purposes of this chapter; and
- (7) Establish actuarial rates and reserve requirements necessary to ensure the financial integrity of all burial associations.

(b) The powers and authority set out in subsection (a) of this section shall not be in diminution or limitation of the powers and authority vested in the board by the various sections of this chapter, but the board shall possess all powers and authority, whether set forth in this section or not, to enable it to carry out the intent and purpose of this chapter.

(c) The board shall have power to conduct hearings, subpoena witnesses and records, determine issues between different burial associations and between burial associations and their respective members, and render binding decisions, subject to appeal as provided in this chapter.

History. Acts 1953, No. 91, §§ 5, 24; A.S.A. 1947, §§ 66-1805, 66-1824; Acts 1987, No. 443, § 2.

CASE NOTES

ANALYSIS

Jurisdiction.
Rules.

Jurisdiction.

Where mortuary and representatives of deceased members of burial association sued association on funeral expenses, jurisdiction was in circuit court not in burial association board as latter adjudicated disputes among associations and between association and its members only. *Hoggard & Sons Enters., Inc. v. Russell Burial Ass'n*, 255 Ark. 576, 501 S.W.2d 613 (1973).

Rules.

An administrative agency's rules must

implement the purpose of the legislation pursuant to which they are made. *Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n*, 302 Ark. 133, 788 S.W.2d 234 (1990).

Amendment to rule 18 and new rules 38 and 39, of the Rules of the Arkansas Burial Association Board, were held invalid pursuant to subdivision (a)(7). *Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n*, 302 Ark. 133, 788 S.W.2d 234 (1990).

Cited: *McEuen Burial Ass'n v. Arkansas Burial Ass'n Bd.*, 298 Ark. 572, 769 S.W.2d 415 (1989).

23-78-109. Burial associations under authority, supervision, and control of board.

All burial associations organized or operating in the State of Arkansas shall be under the authority, supervision, and control of the Burial Association Board.

History. Acts 1953, No. 91, § 6; A.S.A. 1947, § 66-1806.

23-78-110. Certificate of authority.

(a) Applications for certificate of authority shall be on forms furnished by the Burial Association Board, and no burial association shall begin operation until the application shall have been approved and certificate of authority shall have been granted by the board.

(b) The following documents and information shall be filed with the application:

(1) Surety bond payable to the board in the sum of five thousand dollars (\$5,000) executed by the applicant with surety approved by the board, conditioned upon the full compliance with this chapter;

(2) Consent to service of process upon the secretary of the applicant;

(3) Copy of proposed form of membership application, membership certificate, bylaws, and contracts for service, merchandise, supplies, and any other data requested by the board; and

(4) References as to character, ability, and integrity of the organizers and of any funeral director or embalmer with whom the applicant proposes to contract.

(c) If the board is satisfied that the applicant is qualified and meets the requirements of this chapter, it shall issue to the applicant a certificate of authority upon receipt of the sum of five hundred dollars (\$500).

History. Acts 1953, No. 91, § 8; A.S.A. 1947, § 66-1808.

23-78-111. Fees — Oath at payment.

(a)(1)(A) In order to meet the expense of supervision and of carrying out the other provisions of this chapter, the Burial Association Board shall have and is given the power and authority to set license fees for burial associations, subject to its jurisdiction as set forth in § 23-78-109.

(B) The board shall determine the amount of such fees based on a burial association's membership or reserves, or a combination thereof.

(2) The board shall collect the annual license fee from each burial association that is operating and in good standing on January 1 of the year in which the license fee is payable.

(b)(1) The fee shall be due and payable to the board not later than February 1 of each year, and upon payment of the fee, the board shall issue to each burial association a license which shall entitle the association to do business in the State of Arkansas during the calendar year for which the license is issued.

(2) If the license fee for any year shall not be paid within thirty (30) days from the date upon which it is due, the board may revoke and cancel the authorization of the delinquent burial association to transact business in the State of Arkansas.

(c) It shall be the duty of every burial association to certify under oath at the time of the payment of the license fee the true and correct membership of the burial association on January 1 of the applicable year.

(d) If any officer or agent of any burial association shall knowingly or willfully make any false statement with respect to the information required by this section to be furnished, he or she shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than five hundred dollars (\$500) or imprisoned not more than six (6) months, or both.

(e) The board shall have and is given the power and authority to reduce or increase, temporarily or permanently, the fees set forth in subsection (a) of this section if the board deems such an action advisable.

History. Acts 1953, No. 91, § 14; 1973, No. 515, § 1; 1975, No. 380, § 1; 1979, No. 244, § 1; 1981, No. 494, § 2; 1983, No. 784, § 2; 1985, No. 480, § 1; A.S.A. 1947, § 66-1814; Acts 1989, No. 344, § 1; 1995, No. 485, § 1.

23-78-112. Certificate for benefits — Issuance.

(a) No burial association shall issue a certificate for benefits for any member in excess of two thousand five hundred dollars (\$2,500), and no certificate shall provide for free service, merchandise, or supplies in addition to the amount of benefits set forth in the certificate.

(b) If other than the contract funeral home performs the funeral service, the benefit shall be paid to that licensed funeral home on the basis of one hundred percent (100%) of the face amount of the certificate, in cash.

History. Acts 1953, No. 91, § 10; 1985, No. 679, § 3; A.S.A. 1947, § 66-1810; Acts 1987, No. 443, § 1.

CASE NOTES**Certificate Enforcement.**

Amendments to § 23-71-111 and this section preclude strict enforcement of “service and merchandise-only” clauses in both burial certificates and insurance policies; however, no legislative action has yet been taken to amend § 23-40-109, which provides that sellers of pre-need contracts may contract to provide mer-

chandise and services. *Guaranty Nat’l Ins. Co. v. Denver Roller, Inc.*, 313 Ark. 128, 854 S.W.2d 312 (1993).

Cited: *McEuen Burial Ass’n v. Arkansas Burial Ass’n Bd.*, 298 Ark. 572, 769 S.W.2d 415 (1989); *Arkansas Burial Ass’n Bd. v. McEuen Burial Ass’n*, 302 Ark. 133, 788 S.W.2d 234 (1990).

23-78-113. Agent’s license required.

(a) Before any agent or representative shall or may represent any burial association in this state, he or she shall first apply to the Burial Association Board for a license.

(b)(1) The board shall have full power and authority to issue the license upon proof satisfactory to the board that the person is capable of soliciting burial association memberships and is of good moral character and recommended by the association in behalf of which the membership solicitations are to be made.

(2) The board may reject the application of any person who does not meet the requirements herein set out.

(c) The board may revoke the license upon proof satisfactory to it that the licensed agent has violated any section of this chapter.

(d) The license fee shall be ten dollars (\$10.00), and the license must be renewed for each calendar year at the same fee.

(e) It shall not be necessary that the president, vice president, or the secretary-treasurer of any burial association obtain a license for soliciting memberships in any association of which the person is president, vice president, or secretary-treasurer.

(f) Membership certificates shall not be issued by a solicitor in the field, but all applications shall be forwarded to the office of the association, and the certificates shall be issued there and a record made of the issuance at the time the certificate is issued.

History. Acts 1953, No. 91, § 13; 1981, No. 494, § 1; A.S.A. 1947, § 66-1813.

23-78-114. False claim, promise, or representation of agent.

Any burial association official, agent, or representative thereof who, for the purpose of inducing a member of one (1) association to change membership to another association, shall make any false claim, promise, or representation not authorized in the bylaws of the association represented by him or her shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than two hundred fifty dollars (\$250) or imprisoned not more than one (1) year, or both.

History. Acts 1953, No. 91, § 18; A.S.A. 1947, § 66-1818.

23-78-115. Rules and bylaws.

All burial associations shall have and maintain rules and bylaws in such form and with such contents as shall be prescribed by the Burial Association Board.

History. Acts 1953, No. 91, § 9; A.S.A. 1947, § 66-1809.

CASE NOTES

Cited: Drummond Citizens Ins. Co. v. Sergeant, 266 Ark. 611, 588 S.W.2d 419 (1979).

23-78-116. Membership dues and assessments.

(a) From and after February 18, 1953, no burial association organized or operating in this state shall issue any certificate providing benefits for a member for an assessment or membership dues less than the minimum assessment or minimum dues prescribed for the benefits by the Burial Association Board.

(b) However, dues and assessments of the membership as of February 18, 1953, shall not be changed by the board.

History. Acts 1953, No. 91, § 11; A.S.A. 1947, § 66-1811.

23-78-117. Books, records, accounts, and documents — Inspection and audit.

(a) The books, records, accounts, and documents of all burial associations organized or operating in this state shall at all times be open for inspection, examination, and audit by the Burial Association Board, its agents and employees.

(b)(1) Through its agents and employees, the board shall make examinations, from time to time, of all burial associations.

(2)(A) If, at the time of an examination or audit, the board determines that a burial association's books, records, accounts, and documents are insufficient, unavailable, or in no condition to be examined or audited, the board may collect a fee not to exceed one thousand dollars (\$1,000) and recover costs incurred, including the following:

- (i) Round trip mileage from the board office to the burial association, at the travel rate then prevailing for other state employees; and
- (ii) Per-diem expenses at the travel rate then prevailing for other state employees.

(B) Any fees or costs incurred shall not be payable from the burial association's mortuary fund.

(c) The board shall be audited from time to time by the Legislative Joint Auditing Committee.

History. Acts 1953, No. 91, § 12; 1981, No. 360, § 2; A.S.A. 1947, § 66-1812; Acts 1995, No. 485, § 2.

23-78-118. Books — False entries prohibited.

(a) Any person or burial association official who knowingly makes or allows to be made any false entry on the books of the association with intent to deceive or defraud any member thereof, or with intent to conceal the true condition of the association from the Burial Association Board or its agents or employees or any auditor authorized to examine the books of the association under the supervision of the board, shall be guilty of a misdemeanor.

(b) Upon conviction, the person shall be fined not more than two hundred fifty dollars (\$250) or imprisoned not more than one (1) year, or both.

History. Acts 1953, No. 91, § 19; A.S.A. 1947, § 66-1819.

23-78-119. Records — Failure to maintain.

(a) Any burial association secretary or secretary-treasurer who fails to maintain records to the minimum standards required by the Burial Association Board shall be removed by the board from office and another elected by the association in his or her stead.

(b) The election shall be immediately upon notice of the removal.

History. Acts 1953, No. 91, § 20; A.S.A. 1947, § 66-1820.

23-78-120. Semiannual reports.

(a) Each burial association or society licensed in this state shall file a semiannual report showing the actual financial condition of the association as of June 30 and December 31 of each year on forms provided by the Burial Association Board.

(b) The report is due as of June 30 and December 31 of each year and shall be filed within thirty (30) days from the date upon which it is due.

(c) The board shall recover costs incurred in conducting audits and preparing the semiannual report from those associations which fail to file the report prior to the expiration of the deadline referred to in subsection (b) of this section. Costs to be recouped shall include:

(1) Round-trip mileage from the board's office to the association, at the rate then prevailing for other state employees engaged in travel;

(2) Per-diem expenses at the rate then prevailing for other state employees engaged in travel;

(3) Plus a two hundred fifty dollars (\$250) fee for preparing the report.

History. Acts 1953, No. 91, § 14; 1985, No. 480, § 2; A.S.A. 1947, § 66-1814.

23-78-121. Rules and regulations.

The Burial Association Board shall make and promulgate reasonable rules and regulations for the administration of the provisions of this chapter and for the purpose of carrying out the intent hereof. The rules and regulations shall have the full force and effect of statute.

History. Acts 1953, No. 91, § 23; A.S.A. 1947, § 66-1823.

CASE NOTES

Cited: Gregg Burial Ass'n v. Emerson, Home, 25 Ark. App. 18, 751 S.W.2d 356 289 Ark. 47, 709 S.W.2d 401 (1986); Arkansas Burial Ass'n v. Dixon Funeral (1988).

23-78-122. Disposition of collections.

(a)(1)(A) Seventy-five percent (75%) of the collections of any burial association or society shall be solely for the payment of benefits provided by membership certificates and shall not be used for the payment of operating expenses.

(B) The annual license fee shall not be considered an operating expense, and the annual license fee may be paid from the mortuary fund.

(2) However, subject to the reserve requirements established by the Burial Association Board, the association or society may invest any portion of the seventy-five percent (75%) of the collections not needed for the immediate payment of benefits or not needed for the reasonably anticipated payment of benefits in:

(A) United States Treasury bonds, direct or indirect obligations of the federal government;

(B) Bonds, notes, debentures, or other obligations issued by an agency of the United States Government, the principal and interest of which are fully guaranteed by the United States Government, and

mortgages on real estate which are fully guaranteed as to principal and interest by the United States Government or agency thereof;

(C)(i) Preferred stocks of corporations created or existing under the laws of the United States or any state thereof.

(ii) However, the funds shall be invested only in preferred stocks designated as "A" rated or the equivalent by one (1) or more nationally recognized investment services, and approved by the board.

(iii) Further, no more than fifteen percent (15%) of the total funds of any burial association or society available for investment shall be invested in preferred stocks;

(D)(i) Certificates of deposit of any state or national bank in Arkansas which are insured by the Federal Deposit Insurance Corporation.

(ii)(a) However, if the certificates of deposit issued by the bank shall exceed the amount of the certificates of deposit insured by the Federal Deposit Insurance Corporation, the bank shall furnish to the association or secretary and the board or the Executive Secretary of the Burial Association Board evidence of the assignment of bonds or other securities issued by the State of Arkansas or the United States to secure the payment of the certificates.

(b) This may be done by making the assignment through a federal reserve bank or through a correspondent bank.

(c) In the alternative, the issuing bank may make such assignment in such other form or manner as may be approved by the board or the executive secretary;

(E)(i) Savings accounts of any savings and loan association which are insured by the Federal Savings and Loan Insurance Corporation.

(ii)(a) However, if the savings account of the association exceeds the amount of the savings account insured by the Federal Savings and Loan Insurance Corporation, the association shall furnish to the depositing burial association or secretary and the board or the executive secretary evidence of the assignment of bonds, or other securities issued by the State of Arkansas or the United States, to secure payment of the accounts.

(b) The savings and loan association in which the accounts exist shall make the assignment in a form and manner approved by the board or the executive secretary;

(F) "A" rated or better corporate bonds, as designated by one (1) or more nationally recognized investment services; or

(G)(i) "A" rated state and municipal bonds as designated by one (1) or more nationally recognized investment services.

(ii) However, the bonds must be issued by governmental entities in the State of Arkansas, and no more than thirty percent (30%) of the total funds of any burial association or society available for investment shall be invested in state or municipal bonds.

(b) Seventy-five percent (75%) of the interest derived from the investments shall also not be usable for the payment of operating expenses.

History. Acts 1953, No. 91, § 14; 1973, 679, § 4; A.S.A. 1947, § 66-1814; Acts No. 515, § 1; 1975, No. 380, § 1; 1977, No. 1987, No. 443, § 3. 861, § 1; 1981, No. 360, § 3; 1985, No.

CASE NOTES

Cited: McEuen Burial Ass'n v. Arkansas Burial Ass'n Bd., 298 Ark. 572, 769 S.W.2d 415 (1989).

23-78-123. Disposition of fees and charges.

(a)(1) All fees and charges collected by the Burial Association Board under the provisions of this chapter shall be deposited in insured banks in a fund to be known as the "Burial Association Board Fund".

(2) The board is empowered to expend the funds for the requirements, purposes, and expenses of the board under the provisions of this chapter, upon a voucher signed by the Executive Secretary of the Burial Association Board, provided that the total expense for every purpose incurred shall not exceed the total fees and charges collected by the board under the provisions of this chapter.

(b) The operation of the board and the carrying out of the functions set out in this chapter shall be at no expense to the State of Arkansas.

History. Acts 1953, No. 91, § 15; A.S.A. 1947, § 66-1815.

23-78-124. Revocation of certificate, license, charter, etc. — Hearing.

(a) Before revoking any certificate of authority or license granted under the provisions of this chapter or any charter or other authority granted to a burial association under any law effective prior to February 18, 1953, the Burial Association Board shall set the matter down for a hearing.

(b) At least twenty (20) days prior to the date set for the hearing, the board shall notify in writing the burial association or person holding a license of any charges made.

(c) The board shall afford the burial association or person an opportunity to be heard, at which hearing the association or person may be represented by counsel and shall be allowed oral testimony, affidavits, or depositions in reference thereto.

(d)(1) The board shall have power to subpoena and bring before it any person in this state or take the testimony by deposition of any person with the same fees and mileage and in the same manner as prescribed by law in judicial procedure in courts of this state in civil cases. The fees and mileage shall be paid by the party at whose request the witness is subpoenaed.

(2) The board shall also have the power to order the production of any books, records, and documents at the hearing.

(e)(1) If the board determines that the burial association or person is guilty of violation of any provisions of this chapter, its or his or her certificate of authority, charter, license, or other authority shall be revoked.

(2) However, if the burial association or person gives notice of appeal from any adverse decision of the board as set forth in § 23-78-125, then the burial association or person may, at the discretion of the board, continue to operate during the pendency of the appeal.

(3) If the board chooses not to permit the association or person to operate during the pendency of the appeal, then the board shall appoint a person to conduct the business of the association or person until the appeal has been heard.

History. Acts 1953, No. 91, § 17; 1981, No. 360, § 4; A.S.A. 1947, § 66-1817.

23-78-125. Revocation of certificate, license, charter, etc. — Appeal.

(a) Upon the revocation of any certificate of authority, charter, or other authority by the Burial Association Board under any of the provisions of this chapter, the association or person whose certificate of authority, charter, license, or other authority has been revoked shall have the right of appeal from the action of the board revoking the certificate of authority, charter, or other authority to the circuit court of the county in which the burial association may be located.

(b) Appeals shall be made in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(c) Upon receipt of a notice of appeal, the board shall file with the clerk of the circuit court the decision of the board. The clerk of the circuit court shall then transfer the appeal to the civil docket as in cases of appeal from a justice of the peace.

(d) The appeal shall be heard de novo by the court without a jury.

(e) Either party shall have the right of appeal to the Arkansas Supreme Court.

History. Acts 1953, No. 91, § 21; 1981, No. 360, § 5; A.S.A. 1947, § 66-1821.

CHAPTER 79

INSURANCE POLICIES GENERALLY

SUBCHAPTER

- 1. GENERAL PROVISIONS.**
- 2. SUITS AGAINST INSURERS.**
- 3. MINIMUM STANDARDS — COMMERCIAL PROPERTY AND CASUALTY INSURANCE POLICIES.**
- 4. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS ACT.**
- 5. COMPREHENSIVE HEALTH INSURANCE POOL ACT.**
- 6. COVERAGE FOR DIABETES TREATMENT.**
- 7. TAX CREDITS FOR MEDICALLY NECESSARY FOODS.**
- 8. ARKANSAS HEALTH INSURANCE CONSUMER CHOICE ACT.**

SUBCHAPTER.

9. ARKANSAS ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS.
10. HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY INITIATIVE.

RESEARCH REFERENCES

ALR. Division of opinion among judges on same court or among other courts or jurisdictions considering same question, as evidence that particular clause of insurance policy is ambiguous. 4 ALR 4th 1253.

Clause that liability insurance policy may be cancelled by insured by mailing to insurer written notice stating when thereafter such cancellation shall be effective. 11 ALR 4th 456.

Coverage in insurance as extending to liability for punitive or exemplary damages. 16 ALR 4th 11.

Liability of premium finance agency to insurer for consequences of ineffectual cancellation of policy. 26 ALR 4th 346.

Insured's right of action for arbitrary nonrenewal of policy, where insurer has option not to renew. 37 ALR 4th 862.

Actual receipt of cancellation notice mailed by insurer as prerequisite to cancellation of insurance. 40 ALR 4th 867.

"All risks" insurance. 41 ALR 4th 1095.

Partnership or joint venture exclusion in contractor's or other similar comprehensive general liability policy. 57 ALR 4th 1155.

Policy provision limiting time within which action may be brought on the policy

as applicable to tort action by insured against insurer. 66 ALR 4th 859.

Construction and effect of contracts or insurance policies providing pre-need coverage of burial expense or service. 67 ALR 4th 36.

Liability insurer's postless conduct as waiver of, or estoppel to assert, "no-action" clause. 68 ALR 4th 389.

Construction and effect of "rain insurance" policies insuring against rainfall on the date of concert, exhibition game, or the like. 70 ALR 4th 1010.

Insurer's duty, and effect of its failure to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 ALR 4th 9.

What is "flood" within exclusionary clause of property damage policy. 78 ALR 4th 817.

Estoppel of, or waiver by, issuer of life insurance policy to assert defense of lack of insurable interest. 86 ALR 4th 828.

What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy. 86 ALR 4th 886.

Who is "executive officer" of insured within liability insurance policy. 1 ALR 5th 132.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 23-79-101. Definitions.
- 23-79-102. Scope.
- 23-79-103. Insurable interest — Personal insurance.
- 23-79-104. Insurable interest — Property.
- 23-79-105. Application required — Life and accident and health insurance.
- 23-79-106. Application — Use as evidence — Alteration.
- 23-79-107. Application — Statements as representations.

SECTION.

- 23-79-108. Return of premium to rejected applicant.
- 23-79-109. Filing and approval of forms.
- 23-79-110. Forms — Grounds for disapproval.
- 23-79-111. Standard provisions.
- 23-79-112. Contents.
- 23-79-113. Charter or bylaw provisions excluded — Exception.
- 23-79-114. Entitlement notwithstanding policy provisions — Health services performed by professionals not licensed un-

SECTION.

- der Arkansas Medical Practices Act.
- 23-79-115. Entitlement notwithstanding policy provisions — Services performed by outpatient centers.
- 23-79-116. Execution.
- 23-79-117. Underwriters' and combination policies.
- 23-79-118. Noncomplying forms.
- 23-79-119. Construction of policies.
- 23-79-120. Binders.
- 23-79-121. Delivery of policy.
- 23-79-122. Negotiability of premium notes.
- 23-79-123. Renewal by certificate.
- 23-79-124. Assignment.
- 23-79-125. Payment by insurer — Discharge.
- 23-79-126. Forms for proof of loss.
- 23-79-127. Claims administration by insurer not waiver.
- 23-79-128. Right to insure spouse's life.
- 23-79-129. Coverage of newborn infants.
- 23-79-130. Group policies — Offer of coverage for impairment of speech or hearing.
- 23-79-131. Exemption of proceeds — Life insurance.
- 23-79-132. Exemption of proceeds — Group life.
- 23-79-133. Exemption of proceeds — Accident and health insurance.

SECTION.

- 23-79-134. Exemption of proceeds — Annuity contracts — Assignability of rights.
- 23-79-135. Prompt payment of certain claims required.
- 23-79-136. Agreement for insurer to invest premium prohibited.
- 23-79-137. Coverage for adopted minors.
- 23-79-138. Information to accompany policies.
- 23-79-139. Benefits for alcohol or drug dependency treatment.
- 23-79-140. Mammograms.
- 23-79-141. Children's Preventive Health Care Act.
- 23-79-142. Payment for services of psychological examiners.
- 23-79-143. [Repealed.]
- 23-79-144. Minor children — Certain provisions denying or restricting coverage void.
- 23-79-145. [Repealed.]
- 23-79-146. Subrogation recovery.
- 23-79-147. Prescription medication.
- 23-79-148. Medical transportation services.
- 23-79-149. Prescription drug benefits.
- 23-79-150. Health care plan — Health carrier.
- 23-79-151. Liability insurance — Notice requirements prior to expiration of policy.

Effective Dates. Acts 1967, No. 185, § 4: Mar. 28, 1967. Emergency clause provided: "It is hereby found and determined by the General Assembly that the sale or offer for sale of certain investment fund type insurance policies in this State is not in the best interest of the citizens of this State; that such policies and the results to be obtained by the policyholder have often been misrepresented to prospective policyholders, and that such sales and practices should be immediately prohibited. Therefore, an emergency is hereby declared to exist and this Act, being necessary for the immediate preservation of the public peace, health and safety, shall be in effect from the date of its passage and approval."

Acts 1971, No. 34, § 5: Feb. 3, 1971. Emergency clause provided: "It is hereby found and determined by the General As-

sembly that many health and accident, hospitalization and medical service insurance policies, contracts and plans issued and sold to residents of this state provide payment for or reimbursement to the policy holder for expenses incurred for services provided by persons licensed under the Arkansas Medical Practices Act and do not include payment or reimbursement for services of other persons licensed by the other examining boards as found in Arkansas Statutes 72-201 as amended by Arkansas Statutes 72-602; that most policyholders are not aware at the time the policy is purchased that such services are not covered in the policy plan or contract; that it is in the best interests of the citizens of this State that policies, contracts and plans of health insurance hereafter issued in this State include coverage for such services, and that this Act is

immediately necessary to require such coverage. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 298, § 6: Mar. 3, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that many policies of disability insurance and hospital service and medical service contracts or plans offered for sale in this State do not cover newborn infants of an insured until the infant reaches a certain age; that many insureds are not aware that coverage of newborn is excluded and that the exclusion of coverage for such newborn infants creates in many cases a severe hardship on insured parents; that the additional cost of including coverage for newborn infants from the moment of birth is relatively small, and that it is in the best interests of the citizens of this State that all policies of insurance covering hospital and medical service that all contracts and plans for hospital and medical service which covers members of the insured's family also include coverage for newborn infants, and that this Act is immediately necessary to accomplish this purpose. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 841, § 4: Apr. 4, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject to this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 481, § 5: Mar. 13, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that phenylketonuria and hypothyroidism are conditions which cause irreversible damage unless detected and

corrective procedures are taken early in the life of a newborn infant, and that the immediate passage of this Act is necessary to authorize the State Department of Health to adopt necessary rules and regulations to require testing of all newborn infants in this State for phenylketonuria and hypothyroidism. Therefore, an emergency is hereby declared to exist, and this Act being immediately necessary for the preservation of the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 522, § 53: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1985, No. 804, § 33: Apr. 3, 1985. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 99, § 4: Feb. 27, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that many policies of disability insurance hospital service and medical service contracts or plans offered for sale in this state do not cover minors being adopted by an insured until an adoption decree has been issued; that many adoptive parents risk having to pay potentially high costs of medical services rendered to the children they are adopting; and that this Act will promote the policy of encouraging the citizens of this state to adopt children. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall

be in full force and effect from and after its passage and approval."

Acts 1987, No. 456, § 31: Mar. 30, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1987 (1st Ex. Sess.), No. 12, § 3: June 12, 1987. Emergency clause provided: "It is hereby found and determined by the Seventy-Sixth General Assembly, First Extraordinary Session, that the laws of this State concerning insurance matters covered in this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to protect the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1989, No. 772, § 27: Mar. 21, 1989. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1989, No. 860, § 3: "coverages afforded by the act effective January 1, 1990."

Acts 1991, No. 368, § 18: Mar. 6, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that it is in the best interest of the people of the State of Arkansas that child support be collected and medical insurance requirements be enforced in the most expedient manner for all children of this state; that the smooth

transition from current requirements to those of this act require that the provisions become effective upon passage. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 1123, § 25: Apr. 9, 1991. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety all provisions of this Act other than Section 22 shall be in full force and effect from and after July 1, 1991 and Section 22 shall be in full force and effect from and after the passage and approval of this Act."

Acts 1992 (1st Ex. Sess.), No. 72, § 9: Mar. 20, 1992. Emergency clause provided: "It is hereby found and determined by the General Assembly that certain provisions of the Arkansas Code concerning payment of covered services are confusing and misleading and could cause irreparable harm to citizens of Arkansas. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety the provisions of this Act shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 901, § 52: Apr. 6, 1993. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present laws addressed in this omnibus Act on workers' compensation benefits and insurance licensure and other insurance regulatory issues are inadequate for the protection of the Arkansas public and immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this omnibus Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 1015, § 5: Apr. 12, 1993. Emergency clause provided: "It is hereby found and determined by the General As-

sembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 1271, § 6: emergency failed to pass. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws relating to the freedom to select medical providers is currently inadequate to assure total freedom in such selection; and that this act is designed to correct this situation and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 508, § 9: Mar. 2, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that in order to comply with federal mandates and support the Arkansas Department of Health in its efforts to maintain high accreditation standards for mammography facilities, this act should have immediate effect. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1179, § 9: Apr. 11, 1995. Emergency clause provided: "It is hereby found and determined by the Eightieth General Assembly that Arkansas law governing health care coverage for minor children does not conform with current federal requirements set forth in Section 13623 of the Omnibus Budget Reconciliation Act of 1993; that it is in the best interests of the people of the state of Arkansas that the provisions of this act be given immediate effect so that federal funding is not jeopardized and that minor children entitled to health care services be able to receive those services. Therefore, an emergency is hereby declared to exist

and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1999, No. 881, § 28: Mar. 25, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly of the State of Arkansas that the present funeral pre-need laws, employee leasing firm laws, and other insurance laws are inadequate to protect the public. In pertinent part, the changes to the Insurance Code needed to assure the stability of funding for the Fraud Investigation Division of the Department must be enacted in the laws of this state well before the new fiscal year beginning July 1, 1999. The changes to authorized appropriations, as well as changes to the disability (health) insurance laws on individuals to conform to the federal laws on group policies with guaranteed renewability require immediate adoption; and unless this emergency clause is adopted, this act might not become effective until after the beginning of the next fiscal year. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after the date of its passage and approval. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2001, No. 580, § 29: July 1, 2002. However, the commissioner may extend the effective date to a subsequent date, but no later than October 31, 2002, if he finds that implementation of the act is not possible by July 1, 2002.

Acts 2001, No. 580, § 30: Mar. 6, 2001. Emergency clause provided: "It is hereby found and determined by the Eighty-third General Assembly of the State of Arkansas that the present laws on licensure of Arkansas surplus line brokers do not meet compliance with the Gramm-Leach-Bliley Act of 1999, Public Law 106-102, 113 Stat. 1338, and that other insurance laws are inadequate to protect the public; that in pertinent part, the changes to the insur-

ance code are needed to assure compliance with the provisions of that new federal law which do not allow discrimination in licensure of resident and nonresident applicants for insurance by state insurance regulators; that Arkansas must achieve compliance with this new Federal law which was enacted in 1999 and which has a November 12, 2002 compliance deadline in regard to the Arkansas Insurance Department's regulation of agents, brokers, surplus line brokers, and other applicants for individual and corporate licenses; and that implementation after the effective date of this act will require significant time on the part of the industry and the

Arkansas Insurance Department to come into compliance by the November 12, 2002, deadline. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after the date of its passage and approval. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

RESEARCH REFERENCES

Am. Jur. 43 Am. Jur. 2d, Ins., § 183 et seq.

C.J.S. 44 C.J.S., Ins., § 253 et seq., 45 C.J.S., Ins., § 423 et seq.

23-79-101. Definitions.

As used in this section and §§ 23-79-102 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210:

(1) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers made a part thereof; and

(2) "Premium" is the consideration for insurance, by whatever name called. Any assessment, or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for a policy is deemed part of the premium.

History. Acts 1959, No. 148, §§ 269, 270; A.S.A. 1947, §§ 66-3202, 66-3203; Acts 2001, No. 1604, § 78.

Amendments. The 2001 amendment substituted "a policy" for "an insurance contract" in (2).

CASE NOTES

Premium.

Farm bureau membership fees were a prerequisite and not a condition of insurance or a part of the premiums paid to farm bureau mutual insurance companies where (1) the membership fees were divided between the farm bureaus, a federation of farm bureaus, and the national farm bureau organization, with none of

the membership fees going to the mutual insurance companies, (2) county farm bureaus are not in the business of selling insurance, and (3) persons joining farm bureaus join a county farm bureau, rather than a mutual insurance company. *Farm Bureau Policy Holders & Members v. Farm Bureau Mut. Ins. Co.*, 335 Ark. 285, 984 S.W.2d 6 (1998).

23-79-102. Scope.

This section and §§ 23-79-101, 23-79-103 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210 shall not apply as to:

(1) Reinsurance;

(2)(A) Policies or contracts not issued for delivery in this state nor delivered in this state, except upon subjects of insurance, other than life or accident and health insurance, located or to be performed in this state and except as provided in § 23-79-109(e), approval of forms for delivery in jurisdictions where local approval not provided for.

(B) Subdivision (2)(A) of this section shall not apply to group insurance certificates issued under group insurance policies effectuated and delivered outside this state but covering persons resident in this state;

(3) Wet marine and foreign trade insurance; and

(4) Title insurance, except as to the following provisions:

(A) Section 23-79-109, filing, approval of forms;

(B) Section 23-79-110, grounds for disapproval;

(C) Section 23-79-113, charter, bylaw provisions;

(D) Section 23-79-116, execution of policies;

(E) Section 23-79-119, construction of policies; and

(F) Sections 23-79-202 — 23-79-205 and 23-79-208, suits against insurers, etc.

History. Acts 1959, No. 148, § 268; substituted “accident and health” for “disability” in (2); and redesignated former 1979, No. 691, § 1; A.S.A. 1947, § 66-3201; Acts 2001, No. 1604, § 79. subdivision (5) as (2)(B).

Amendments. The 2001 amendment

23-79-103. Insurable interest — Personal insurance.

(a)(1) Any individual of competent legal capacity may procure or effect an insurance contract upon his or her own life or body for the benefit of any person.

(2) However, no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to:

(A) The individual insured or his or her personal representatives;
or

(B) A person having an insurable interest in the individual insured at the time the contract was made.

(b) If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement, or injury of the individual insured, the individual insured or his or her executor or administrator, as the case may be, may maintain an action to recover the benefits from the person so receiving them.

(c)(1) “Insurable interest” with reference to personal insurance includes only interests as follows:

(A) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

(B) In the case of persons to which subdivision (c)(1)(D) of this section does not apply, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest that would arise only by, or would be enhanced in value by, the death, disablement, or injury of the individual insured;

(C) An individual party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, as an insurable interest in the life of each individual party to the contract and for the purposes of the contract only, in addition to any insurable interest that may otherwise exist as to the life of the individual; and

(D)(i)(a) Any employer, corporation, other business entity, or the trustee of a trust providing life, health, disability, retirement, or similar benefits to employees, retired employees, or their dependents or beneficiaries has an insurable interest in the lives of employees for whom the benefits are to be provided.

(b) Any employer, corporation, business entity, or trustee of a trust under subdivision (c)(1)(D)(i)(a) of this section may purchase, accept, or otherwise acquire an interest in personal insurance as a beneficiary or owner.

(ii)(a) Employers have a lawful and substantial economic interest in the lives of key employees and in other employees who have a reasonable expectation of benefiting from a pension and welfare benefit plan.

(b) Any employer, corporation, business entity, or trustee under this subdivision (c)(1)(D) shall obtain the consent of any employee for which it obtained personal insurance, if the personal insurance purchased names the employer, corporation, business entity, or the trustee as a beneficiary.

(c) Consent required under subdivision (c)(1)(D)(ii)(b) of this section shall include an acknowledgement that the employer may maintain the life insurance coverage after the insured individual's employment has terminated.

(d) No employer, corporation, business entity, or trustee may lawfully retaliate against any person for refusing to consent to the issuance of insurance on that person.

(e) For a nonkey or nonmanagerial employee, the amount of coverage shall be reasonably related to the benefits provided to the employee.

(f) The life insurance coverage purchased to finance employer-provided pension and welfare benefit plans shall be allowed only on the lives of those employees and retirees who have a reasonable expectation of benefiting from the plan at the time their lives are first insured under the plan.

(2)(A) Notwithstanding any other law or regulation to the contrary, any religious, educational, charitable, or benevolent institution,

organization, corporation, association, or trust, including, but not limited to, charitable remainder trusts, may be named beneficiary or owner, or both, of the policy or contract by any applicant for insurance upon his or her own life in any policy of life insurance issued by any life insurance company authorized to do business in this state or in the state of domicile of the applicant for insurance.

(B) The applicant for insurance shall be deemed to have an unlimited insurable interest in his or her own life, and is entitled to name any of the institutions as beneficiary of the insurance, and the beneficiaries or owners, or both, shall have the right to receive all death benefits provided for by such policies and to exercise the rights of ownership if granted same.

(C) As to any life insurance policies heretofore issued by insurers naming any of the institutions referred to in this section as beneficiaries or owners, or both, if the applicant for insurance was also the insured, the beneficiaries or owners shall be entitled to receive all death benefits provided by the policy and to exercise the rights of ownership if granted same.

History. Acts 1959, No. 148, § 271; A.S.A. 1947, § 66-3204; Acts 1989, No. 773, § 1; 1993, No. 1015, § 1; 2003, No. 472, § 1.

Amendments. The 2003 amendment substituted “In the case of persons to

which subdivision (c)(1)(D) of this section does not apply” for “In the case of other persons” in (c)(1)(B); rewrote (c)(1)(D); and made minor stylistic and punctuation changes.

RESEARCH REFERENCES

UALR L.J. Survey, Insurance, 12 UALR L.J. 643.

CASE NOTES

Insurable Interest.

The bank was not precluded from recovering on policy on the contention that it had no insurable interest. *Bank Credit Life Ins. Co. v. Pine Bluff Nat'l Bank*, 247 Ark. 922, 448 S.W.2d 333 (1969).

Where credit life insurance policy stood only as an additional security for loan, accommodation maker's administrator

should neither be subrogated nor was entitled to recover benefits unless the accommodation maker had an insurable interest. *Moore v. Hansen*, 250 Ark. 367, 465 S.W.2d 684 (1971).

Cited: *International Harvester Credit Corp. v. Hurst*, 268 Ark. 632, 594 S.W.2d 582 (Ct. App 1980).

23-79-104. Insurable interest — Property.

(a) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured at the time of the effectuation of the insurance and at the time of the loss.

(b) “Insurable interest” as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation

of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

History. Acts 1959, No. 148, § 272; A.S.A. 1947, § 66-3205.

CASE NOTES

ANALYSIS

Construction.

Insurable interest.

No insurable interest.

Payment of proceeds.

Construction.

Under this section, it is imperative that claimant show an insurable interest not only at the time the insurance went into effect, but at the time the loss occurred. *Morse v. Morse*, 60 Ark. App. 215, 961 S.W.2d 777 (1998).

Insurable Interest.

Property buyers who paid down payment on two houses, and were to pay the balance later, had an insurable interest within the meaning of this section when one of the houses burned down. *Thurston Nat'l Ins. Co. v. Hays*, 260 Ark. 855, 544 S.W.2d 853 (1977).

Where at the time of fire, the seller of machinery was still indebted for a portion of the original purchase price of the machine, he had an insurable interest in it and even if title had already passed to buyer prior to such fire such interest was not destroyed thereby. *Hartford Fire Ins. Co. v. Stanley*, 7 Ark. App. 94, 644 S.W.2d 628 (1983).

Bailee of automobile has an insurable interest, and redelivery of the vehicle does not necessarily terminate the bailment. *Hinkle v. Perry*, 296 Ark. 114, 752 S.W.2d 267 (1988).

Two parties can have independent insurable interests in one piece of property. *Beatty v. USAA Cas. Ins. Co.*, 330 Ark. 354, 954 S.W.2d 250 (1997).

Where minor daughter had an insurable interest in the automobile, guardian's legal obligation to exercise prudence and due care in managing the estate of the minor gave the guardian an insurable interest in the automobile on behalf of the minor. *Beatty v. USAA Cas. Ins. Co.*, 330 Ark. 354, 954 S.W.2d 250 (1997).

The plaintiffs had an insurable interest

in a residence and the property therein, regardless of the fact that they were not the titled owners of the residence, where (1) they lived at the residence for several years prior to the fire and made improvements to the home by constructing a garage and a two-story addition, (2) title was placed in the names of the parents of one of the parties because the home was purchased while the parties were separated, but attempting a reconciliation, and (3) the plaintiffs actually paid all the mortgage payments, insurance, and taxes on the home, and also paid for the improvements to the property. *Farm Bureau Mut. Ins. Co. v. Foote*, 341 Ark. 105, 14 S.W.3d 512 (2000).

No Insurable Interest.

The confirmation of the foreclosure sale and the delivery of a commissioner's deed to the buyer had the effect of terminating appellant's insurable interest in the property. *Marion v. Town & Country Mut. Ins. Co.*, 59 Ark. App. 120, 952 S.W.2d 681 (1997).

Creditor in bankruptcy proceeding had no "insurable interest" beyond the value of the collateral securing the loan creditor made to debtor. *In re Gibson*, 218 Bankr. 900 (Bankr. E.D. Ark. 1998).

Where claimant was married at the time the house was insured, but divorced when the house, occupied by the ex-husband, was destroyed, claimant was not entitled to any of the insurance proceeds paid to the husband; claimant had no insurable interest in the house at the time of the loss. *Morse v. Morse*, 60 Ark. App. 215, 961 S.W.2d 777 (1998).

Payment of Proceeds.

Insurance proceeds are payable only to the person whose interest is covered by the policy, provided he has an insurable interest at the time of the making of the contract and at the time of the loss. *Wilbanks & Wilbanks, Inc. v. Cobb*, 269 Ark. 936, 601 S.W.2d 601 (Ct. App. 1980).

Cited: *Gravning v. American Druggists'*

Ins. Co., 259 Ark. 523, 534 S.W.2d 754 (1976); *Adams v. Allstate Ins.*, 723 F. Supp. 111 (E.D. Ark. 1989); *Colonia Underwriters Ins. Co. v. Worthen Nat'l Bank*,

53 Ark. App. 106, 919 S.W.2d 515 (1996); *Hartford Ins. Co. v. Brewer*, 54 Ark. App. 1, 922 S.W.2d 360 (1996).

23-79-105. Application required — Life and accident and health insurance.

No life or accident and health insurance contract upon an individual, except a contract of group life insurance or of group or blanket accident and health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

- (1) A spouse may effectuate the insurance upon the other spouse;
- (2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of, or pertaining to, the minor;
- (3) The application for accident insurance procured through a vending machine licensed under § 23-64-221 must be signed by the individual to be so insured or, if the individual to be so insured does not have legal capacity to contract, the application must be signed by the individual's parent, guardian, or other legally constituted representative; and
- (4) Family policies may be issued insuring any two (2) or more members of a family on an application signed by either parent, a stepparent, or by a husband or wife.

History. Acts 1959, No. 148, § 273; A.S.A. 1947, § 66-3206; Acts 2001, No. 580, § 22; 2001, No. 1604, § 80.

Amendments. The 2001 amendment by No. 580 substituted “§ 23-64-221” for “§ 23-64-223” in (3).

The 2001 amendment by No. 1604 substituted “accident and health” for “disability” in the section heading and introductory language; and substituted “23-64-221” for “23-64-223” in (3).

RESEARCH REFERENCES

UALR L.J. *Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law*, 4 UALR L.J. 17.

Seventeenth Annual Survey of Arkansas Law — Insurance, 17 UALR L.J. 451.

Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

CASE NOTES

ANALYSIS

In general.
Construction.
Consent.
Legislative intent.
Liability of insurer.

In General.

It is conceivable that a person can apply for insurance without actually signing the application; the policy is satisfied when the insured, having personally applied for the insurance, is aware of who would be the beneficiary in the event of his death,

and the presence of his signature would not be critical to proving the knowledge contemplated by this section's underlying policy, and his failure to sign the application does not frustrate this section's purpose when there is other proof available to demonstrate that the insured applied for insurance. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

Construction.

This section permits a life insurance policy to be issued if the insured applies for insurance and does not require that the insured personally sign the application form. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

The modifying phrase "in writing" in the introductory paragraph of this section applies only when the insured "consents to" insurance and does not apply when the insured has "applied for" insurance. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

The phrase imposing a writing requirement modifies only one side of the disjunctive; thus, it only applies when an insured consents to insurance without actually applying for it. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

Consent.

The writing of personal check by insured for a cashier's check to pay the premium on the policy was a sufficient consent in writing to the issuance of the policy. *Constitution Life Ins. Co. v. M.D. Thompson & Son*, 251 Ark. 784, 475 S.W.2d 165 (1972).

One who takes out a policy of insurance on the life of another without the knowledge or consent of the latter, cannot main-

tain an action against the insurance company on the policy; it is against public policy to allow one person to have insurance on the life of another without the knowledge of the latter. *Cableton v. Gulf Life Ins. Co.*, 12 Ark. App. 257, 674 S.W.2d 951 (1984).

Neither the alleged oral consent of the insured to the application for a policy of life insurance nor the purported waiver of requirements of ratification by insurer is effective to negate the mandatory invalidation of life insurance policies issued without an application or consent in writing by the insured. *Hunt v. Pyramid Life Ins. Co.*, 21 Ark. App. 261, 732 S.W.2d 167 (1987).

Legislative Intent.

This section codifies the policy against allowing one person to have insurance on the life of another without the knowledge of the latter. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

The legislature did not intend to require that applications for life insurance be signed by insured because if it had it would have clearly stated so like it did in subdivision (3) of this section. *Walker v. Jackson Nat'l Life Ins. Co.*, 20 F.3d 923 (8th Cir. 1994).

Liability of Insurer.

Since the requirements of this section are nonwaivable, insurer's acceptance of premiums does not provide a basis for a finding of liability on insurer's part. *Hunt v. Pyramid Life Ins. Co.*, 21 Ark. App. 261, 732 S.W.2d 167 (1987).

Cited: *Garner v. Foundation Life Ins. Co.*, 17 Ark. App. 13, 702 S.W.2d 417 (1986).

23-79-106. Application — Use as evidence — Alteration.

(a) No application for the issuance of any life or accident and health insurance policy or annuity contract shall be admissible in evidence in any action relative to the policy or contract unless a true copy of those portions of the application signed by the applicant was attached to, or otherwise made a part of, the policy or contract when issued.

(b)(1) If any policy of life or accident and health insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer, within thirty (30) days after receipt of the request at its home office or at any of its branch offices, shall deliver or mail to the person making the request a copy of the application.

(2) If the copy is not delivered or mailed after having been requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

(3) In the case of a request from a beneficiary, the time within which the insurer is required to furnish a copy of the application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.

(c) No alteration of any written application for any life or accident and health insurance policy shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

History. Acts 1959, No. 148, § 274; A.S.A. 1947, § 66-3207; Acts 2001, No. 1604, § 81.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (a), (b)(1), and (c); deleted "This

provision shall not apply to industrial life insurance policies" at the end of (a); redesignated former (b) as present (b)(1) and redesignated the remaining subsections accordingly; and inserted "or her" in (c).

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-79-107. Application — Statements as representations.

(a) All statements in any application for a life or accident and health insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

- (1) Fraudulent;
- (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(3) The insurer in good faith would not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to the insurer as required by the application for the policy or contract or otherwise.

(b) In any action to rescind any policy or contract or to recover thereon, if any misrepresentation with respect to a medical impairment is proved by the insurer and the insured or any other person having or claiming a right under the contract shall prevent full disclosure and proof of the nature of the medical impairment, then the misrepresentation shall be presumed to have been material.

(c) In any action to rescind any policy or contract or to recover thereon, a misrepresentation is material if there is a causal relationship between the misrepresentation and the hazard resulting in a loss under the policy or contract.

History. Acts 1989, No. 662, § 1; 2001, No. 1604, § 82.

Publisher's Notes. Former § 23-79-107 concerning Application — Statements as representations, was repealed by Acts 1989, No. 662, § 2. The former section

was derived from Acts 1959, No. 148, § 275; A.S.A. 1947, § 66-3208.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in the introductory language of (a).

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992 Insurance Law Decisions, 1992 Ark. L. Notes 85.

Ark. L. Rev. Young, Insurance Policy Defenses: In Search of Restatements, 34 Ark. L. Rev. 507.

UALR L.J. Bassett, Survey of Arkansas Law: Insurance, 2 UALR L.J. 247.

Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

Survey, Insurance, 11 UALR L.J. 231.

Survey, Insurance, 12 UALR L.J. 643.

CASE NOTES

ANALYSIS

In general.

Construction.

Applicability.

Evidence.

Interpretation.

Knowledge of agent.

Misrepresentations, omissions, etc.

In General.

An insurer can establish an affirmative defense to recovery under a policy by showing that there has been a misrepresentation, omission, concealment of facts, or incorrect statement in the insurance application. *Jackson v. Prudential Ins. Co. of Am.*, 736 F.2d 450 (8th Cir. 1984) (decision under prior law).

Construction.

Subsection (c), which was added by Act 662 of 1989, is not to be applied retroactively. *Carmichael v. Nationwide Life Ins. Co.*, 305 Ark. 549, 810 S.W.2d 39 (1991).

Applicability.

The statute did not apply to an action in which the insureds contested their insurer's failure to pay a claim for a fire loss on the basis that the insureds had knowingly misrepresented material facts on their claim of loss and during the insurer's investigation of the fire; the statute de-

scribes only the conditions under which an insurer may avoid liability due to misstatements made in the application for insurance. *Willis v. State Farm Fire & Cas. Co.*, 219 F.3d 715 (8th Cir. 2000).

Evidence.

Testimony of a soliciting agent of insurer that he was directed not to send to the home office any application for insurance in which certain questions were answered affirmatively was admissible in support of a defense under subdivision (a)(3) of this section. *American Family Life Assurance Co. v. Reeves*, 248 Ark. 1303, 455 S.W.2d 932 (1970) (decision under prior law).

Interpretation.

When a question calls for an answer based on interpretation of known facts and circumstances, as distinguished from a simple disclosure of historical facts, the response is measured under this section by whether the individual answering the question was justified in the belief expressed. *Citizens Bank v. Western Employers Ins. Co.*, 865 F.2d 964 (8th Cir. 1989) (decision under prior law).

Knowledge of Agent.

Recovery under an insurance contract would not be barred because the insured,

who had been under a doctor's care, signed a statement that he was in good health, where the soliciting agent had been told in detail of the insured's condition. *Ford Life Ins. Co. v. Jones*, 262 Ark. 881, 563 S.W.2d 399 (1978), overruled on other grounds, *Southern Farm Bureau Life Ins. Co. v. Cowger*, 295 Ark. 250, 748 S.W.2d 332 (1988) (decision under prior law).

The general rule is that notice to a soliciting agent is not notice to the insurance company; a soliciting agent has no authority to waive policy requirements and his knowledge of misrepresentations cannot be imputed to the insurer. *Jackson v. Prudential Ins. Co. of Am.*, 736 F.2d 450 (8th Cir. 1984) (decision under prior law).

Insurer held estopped to deny payment of claims where agent incorrectly filled out the application. *Stuckey v. Time Ins. Co.*, 669 F. Supp. 261 (E.D. Ark. 1987), *aff'd*, 860 F.2d 1084 (8th Cir. 1988); *Time Ins. Co. v. Graves*, 21 Ark. App. 273, 734 S.W.2d 213 (1987) (decision under prior law).

Insurer properly denied husband's claim on a life insurance policy issued on wife, where the information reported on the insurance application materially misrepresented her true medical history; even though the insurance agent who filled out the application knew of wife's true medical history, the soliciting agent's knowledge could not be imputed to the insurer. *Hall v. Modern Woodmen of Am.*, 68 F.3d 1120 (8th Cir. 1995).

Misrepresentations, Omissions, Etc.

Information supplied by applicant, although incomplete, substantially met all burdens imposed upon him in his relations with the insurer. *Old Am. Life Ins. Co. v. McKenzie*, 240 Ark. 984, 403 S.W.2d 94 (1966) (decision under prior law).

False statement of the wife of the applicant for a rider making an insurance policy to her was sufficient to prevent recovery upon the policy under subdivision (a)(3) even though such statement was not made by the applicant and was not known by him to be false. *Dopson v. Metropolitan Life Ins. Co.*, 244 Ark. 659, 426 S.W.2d 410 (1968) (decision under prior law).

It does not matter that the deceased did not knowingly or fraudulently make false statements which induced the issuance of the policy where the insurer would not in

good faith have issued the policy except for omissions material to the risk or other material incorrect statements. *Life & Cas. Ins. Co. v. Smith*, 245 Ark. 934, 436 S.W.2d 97 (1969) (decision under prior law).

Where an insurance company asks exemption from liability based on misrepresentation, it has the burden to show that facts misrepresented were fraudulent, material to the risk, or that it would not have issued the policy. *Hartford Life Ins. Co. v. Catterson*, 247 Ark. 263, 445 S.W.2d 109 (1969); *Combined Ins. Co. of Am. v. Yates*, 253 Ark. 963, 490 S.W.2d 134 (1973) (decision under prior law).

A statement by an applicant which forms the basis for issuance of a policy which is untrue and material to the risk, precludes recovery on the policy whether or not the statement was fraudulent. *Union Life Ins. Co. v. Davis*, 247 Ark. 1054, 449 S.W.2d 192 (1970) (decision under prior law).

A "good health" statement on an application for insurance is incorrect when the insured is aware of an affliction which would seriously affect the risk. *Union Life Ins. Co. v. Davis*, 247 Ark. 1054, 449 S.W.2d 192 (1970); *Ford Life Ins. Co. v. Samples*, 277 Ark. 351, 641 S.W.2d 708 (1982), overruled on other grounds, *Southern Farm Bureau Life Ins. Co. v. Cowger*, 295 Ark. 250, 748 S.W.2d 332 (1988) (decision under prior law).

A diagnosis of certain heart disease and related ailments shows that a person is not free from such disease as would be material to the hazard assumed by the insurer. *Union Life Ins. Co. v. Davis*, 247 Ark. 1054, 449 S.W.2d 192 (1970) (decision under prior law).

An insurer may assert a defense under subdivision (a)(3) where a statement in the application for a policy, although made in good faith, was in fact incorrect and the insurer in good faith would not have issued the policy if the true facts had been known to the insurer. *American Family Life Assurance Co. v. Reeves*, 248 Ark. 1303, 455 S.W.2d 932 (1970) (decision under prior law).

Insurer held not liable on policy because of misrepresentation by insured. *Marshall v. Prudential Ins. Co. of Am.*, 253 Ark. 127, 484 S.W.2d 892 (1972); *American Pioneer Life Ins. Co. v. Smith*, 255 Ark. 949, 504 S.W.2d 356 (1974); *Southern Sec. Life Ins.*

Co. v. Smith, 259 Ark. 853, 537 S.W.2d 542 (1976) (decision under prior law).

It was a question of fact for the jury whether insured's failure to disclose certain facts in the insurance application would have resulted in rejection of his application. Combined Ins. Co. of Am. v. Yates, 253 Ark. 963, 490 S.W.2d 134 (1973) (decision under prior law).

Where insurer failed to show that the deceased knew that the statement was a misrepresentation, policy was not rendered void. Ford Life Ins. Co. v. Samples, 277 Ark. 351, 641 S.W.2d 708 (1982), overruled on other grounds, Southern Farm Bureau Life Ins. Co. v. Cowger, 295 Ark. 250, 748 S.W.2d 332 (1988) (decision under prior law).

An insurer may defend a policy claim on the ground of a misrepresentation which caused the issuance of the policy but with respect to which the fact or facts misrepresented were not necessarily related to the loss sustained. Southern Farm Bureau Life Ins. Co. v. Cowger, 295 Ark. 250, 748 S.W.2d 332 (1988).

Where beneficiary used medical privilege to prevent the insurer from finding out how much knowledge debtor had of his physical condition, materiality of statement was presumed and need not be proved. American Pioneer Life Ins. Co. v. Turman, 254 Ark. 456, 495 S.W.2d 866 (1973) (decision under prior law).

Where the insurer rescinded personal representative's father's health insurance for alleged misrepresentations about a preexisting lung disease, the appellate court found that, in addition to the personal representative's testimony that the father was unaware of the condition, the physician's progress note mentioned only

"some degree of chronic obstructive pulmonary disease (COPD)," and contained the notations "bronchitis and sinus congestion"; thus, a jury might have concluded that, to the best of the father's knowledge and belief, the father had not been diagnosed with COPD, and summary judgment for the insurer was improper. McQuay v. Ark. Blue Cross & Blue Shield, 81 Ark. App. 77, 98 S.W.3d 454 (2003).

Burden was on the insurer to sustain its contention that the facts not disclosed by the decedent were material to the risk assumed by it or that, in good faith, it would not have issued the policy had it known the true facts; the insurer did not prove that there was a nondisclosure of the decedent's illness that would allow for summary judgment. Burnett v. Phila. Life Ins. Co., 81 Ark. App. 300, 101 S.W.3d 843 (2003).

Cited: Van Houten v. Better Health Ins. Ass'n, 238 Ark. 815, 384 S.W.2d 465 (1964); Motors Ins. Corp. v. Tinkle, 253 Ark. 620, 488 S.W.2d 23 (1972); United States v. Williams, 545 F.2d 47 (8th Cir. 1976); Findley v. Time Ins. Co., 269 Ark. 257, 599 S.W.2d 736 (1980); Capitol Old Line Ins. Co. v. Gorondy, 1 Ark. App. 14, 612 S.W.2d 128 (1981); Jackson v. Prudential Ins. Co. of Am., 564 F. Supp. 229 (W.D. Ark. 1983); Twin City Bank v. Verex Assurance, Inc., 733 F. Supp. 67 (E.D. Ark. 1990) (preceding decisions under prior law); Rooney v. Williamson, 167 F.3d 1185 (8th Cir. 1999); Richison v. Boatmen's Ark., Inc., 64 Ark. App. 271, 981 S.W.2d 112 (1998); Farm Bureau Mut. Ins. Co. v. Foote, 341 Ark. 105, 14 S.W.3d 512 (2000); Capital Life & Accident Ins. Co. v. Phelps, 76 Ark. App. 428, 66 S.W.3d 678 (2002).

23-79-108. Return of premium to rejected applicant.

After an insurer rejects or declines to issue a life or accident and health insurance policy, the insurer shall return the premium to the applicant within a reasonable period of time.

History. Acts 1985, No. 793, § 1; A.S.A. 1947, § 66-2027; Acts 2001, No. 1604, § 83.

Amendments. The 2001 amendment substituted "accident and health" for "disability."

23-79-109. Filing and approval of forms.

(a)(1)(A) No basic insurance policy, or annuity contract form, or application form when written application is required and is to be

made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner.

(B) This subsection shall not apply to:

(i) Policy or coverage forms for large commercial risks, as defined in subsection (g) of this section;

(ii) Commercial umbrella policy or coverage forms;

(iii) Excess umbrella policy or coverage forms;

(iv) Excess of loss policy or coverage forms;

(v) Public officials' liability policy or coverage forms;

(vi) Fiduciary liability policy or coverage forms;

(vii) Directors' and officers' liability policy or coverage forms;

(viii) Kidnap and ransom policy or coverage forms;

(ix) Political risk policy or coverage forms;

(x) Expropriation coverage policy or coverage forms;

(xi) Mortgage pool insurance policy or coverage forms;

(xii) Railroad protective liability policy or coverage forms;

(xiii) Equity loan programs, second mortgage coverage, policy or coverage forms;

(xiv) Highly protected risk forms;

(xv) Surety bonds; or

(xvi) Policies, orders, endorsements, or forms of unique character designed for, and used with relation to, insurance upon a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life and accident and health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder.

(C) The exemption of a particular type of insurance policy form from the requirement that it be filed with the commissioner and expressly approved thereby is not to be taken by an insurer as meaning that any insurance effected by the use of such a form may in any fashion be inconsistent with the statutory and common law of this state that is properly applicable thereto.

(2) As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner.

(3) No group accident and health certificate of insurance may be extended to residents of this state under a group accident and health policy issued outside this state that does not include the provisions required for group policies issued in this state unless the commissioner determines that the provisions are not appropriate for the coverage provided. Upon request of the commissioner, copies of the group accident and health policies issued outside this state shall be made available on an informational basis.

(4) On and after January 1, 1990, all medicare supplement rates shall be based on a composite age basis only and shall not be based on any age banding or other groupings.

(5) Nothing in this subsection shall prohibit an insurer or hospital and medical service corporation issuing medicare supplement insurance policies from using its usual and customary underwriting procedures or excluding preexisting health conditions. However, no insurer shall refuse to issue a medicare supplement policy based solely on the age of the applicant.

(b)(1) Every filing shall be made not less than thirty (30) days in advance of any delivery. At the expiration of the thirty (30) days, the form or rate so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the commissioner.

(2) Approval of the form or rate by the commissioner shall constitute a waiver of any unexpired portion of the waiting period.

(3) The commissioner may extend by not more than an additional thirty (30) days the period within which he or she may so affirmatively approve or disapprove the form or rate by giving notice of the extension before expiration of the initial thirty-day period.

(4) At the expiration of the period as so extended, and in the absence of prior affirmative approval or disapproval, the form or rate shall be deemed approved.

(5) The commissioner may at any time, after notice and for cause shown, withdraw approval.

(c) Notification disapproving the form or withdrawing a previous approval shall state the grounds therefor.

(d) By order, the commissioner may exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof as specified in the order to which, in his or her opinion, this section may not practically be applied or the filing and approval of which are, in his or her opinion, not desirable or necessary for the protection of the public.

(e) This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by that official, and upon the commissioner's written notice requiring the form to be submitted to him or her for the purpose. The same standards that are applicable to forms for domestic use shall apply to such forms.

(f) No policy or contract form providing coverage for personal automobile liability that provides for a policy term of less than six (6) months shall be approved by the commissioner or issued for delivery in this state and used by insurers on and after January 1, 1992. However, the provisions of this subsection shall not restrict premium payment options offered by insurers.

(g)(1) For purposes of this section, "large commercial risk" means an insured that has:

(A) A total premium of two hundred fifty thousand dollars (\$250,000) or more for property and casualty insurance;

(B) At least twenty-five (25) full-time employees; and

(C) A full-time certified risk manager to procure property and casualty insurance. For purposes of this subsection, “certified risk manager” means a risk manager with one (1) or more of the following credentials:

- (i) Associate in risk management;
- (ii) Chartered property casualty underwriter; or
- (iii) Certified risk manager.

(2) The exemption for large commercial risk policy or coverage forms set forth in subdivision (a)(1) of this section shall not apply to workers’ compensation, or employers’ liability or professional liability insurance, including, but not limited to, medical malpractice insurance.

(3)(A) In procuring coverage, a large commercial risk shall certify that it:

- (i) Meets the eligible criteria for an exempt commercial policyholder set out in this subsection;
- (ii) Is aware that the policy is unregulated for rates and forms; and
- (iii) Has the necessary expertise to negotiate its own policy language.

(B) This certification shall be completed annually and remain on file with the producing agent or broker.

(h) If the commissioner deems that the review as to either rates or forms, or both, required by this section as to any particular line or lines of insurance, can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for such period as is deemed appropriate, or until revoked.

History. Acts 1959, No. 148, § 276; 1975, No. 841, § 1; 1979, No. 691, § 2; 1981, No. 809, § 13; 1985, No. 804, § 1; A.S.A. 1947, § 66-3209; Acts 1987, No. 268, § 1; 1989, No. 710, § 2; 1989, No. 815, § 1; 1991, No. 1123, § 11; 1992 (1st Ex. Sess.), No. 72, § 1; 1993, No. 901, § 39; 1999, No. 458, §§ 3, 4; 2001, No. 1604, §§ 84-87.

Publisher’s Notes. Acts 1985, No. 804, § 32, provided, in part, that the act would be cumulative of prior laws, and that no prior law or part of a law would be deemed to be in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Acts 1989, No. 710, § 1, provided: “The purpose of this act is to assure that persons over the age of sixty-five (65) and eligible for Medicare, no matter how advanced in age, may have the opportunity

to purchase or retain Medicare Supplement Insurance at more affordable prices. The implementation of this act is intended to effectively level the cost as related to age, of such insurance for persons over age sixty-five (65) of this state, thereby addressing the increasingly pervasive problem of Medicare Supplement Insurance premiums pricing persons eligible for Medicare out of the supplement market.”

Amendments. The 1999 amendment redesignated the former first and second sentences of (a)(1) as (a)(1)(A) and (B), respectively; inserted “policy or coverage forms for large commercial risks, as defined in subsection (g) of this section” in (a)(1)(A); and added (g).

The 2001 amendment substituted “accident and health” for “disability” in (a)(1)(A)-(B) and (a)(3); and added (h).

23-79-110. Forms — Grounds for disapproval.

The Insurance Commissioner shall disapprove any form filed under § 23-79-109, or withdraw any previous approval, only if the form:

(1) Is in any respect in violation of or does not comply with this code;

(2) Contains or incorporates by reference, when the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) Has any title, heading, or other indication of its provisions that is misleading;

(4) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision;

(5)(A) Is an individual accident and health contract in which the benefits are unreasonable in relation to the premium charge. Rates on a particular policy form will be deemed approved upon filing with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee. Benefits will continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer of the insurer, and must contain at least the following:

(i) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(ii) A guarantee that the actual Arkansas loss ratios for the experience period in which the new rates take effect, and for each experience period thereafter until new rates are filed, will meet or exceed the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If the annual earned premium volume in Arkansas under the particular policy form is less than one million dollars (\$1,000,000) and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nationwide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars (\$1,000,000), the experience period will be extended until the end of the calendar year in which one million dollars (\$1,000,000) of earned premium is attained;

(iii) A guarantee that the actual Arkansas, or national, if applicable, loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the commissioner not later than the date for filing the applicable accident and health policy experience exhibit;

(iv)(a) A guarantee that affected Arkansas policyholders will be issued a proportional refund, based on premium earned of the

amount necessary to bring the actual aggregate loss ratio up to the loss ratio standards referred to in subdivision (a)(5)(A)(i) of this section. If nationwide loss ratios are used, then the total amount refunded in Arkansas will equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in Arkansas on the policy form and divided by the total premium earned in all states on the policy form.

(b) The refund must be made to all Arkansas policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal ten dollars (\$10.00) or more.

(c) The refund will include statutory interest from the end of the experience period until the date of payment.

(d) Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due; and

(v) A guarantee that refunds of less than ten dollars (\$10.00) will be aggregated by the insurer and paid to the State Insurance Department.

(B) As used in this section, the term “loss ratio” means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.

(C) As used in this section, the term “experience period” means, for any given rate filing for which a loss ratio guarantee is made, the period beginning on the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns one million dollars (\$1,000,000) in premium on the form in question in Arkansas or, if the annual premium earned on the form in Arkansas is less than one million dollars (\$1,000,000) nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.

(D)(i) An insurer whose rates on a policy form are approved pursuant to a loss ratio guarantee shall provide affected policyholders with a notice that advises that rates may be increased more than one (1) time a year. For new policyholders with policies subject to the loss ratio guarantee, the notice must be delivered no later than delivery of the policy.

(ii) Nothing in this section shall be deemed to require an insurer to provide the notice required by this subdivision on more than one (1) occasion to any given policyholder while insured under the guaranteed form.

History. Acts 1959, No. 148, § 277; 1975, No. 841, § 2; 1985, No. 530, § 1; A.S.A. 1947, § 66-3210; Acts 1991, No. 398, § 1; 2001, No. 1604, §§ 88, 89.

Amendments. The 2001 amendment substituted “accident and health” for “dis-

ability” in the introductory language of (a)(5)(A); and deleted (b).

Meaning of “this code”. Acts 1959, No. 148, codified as set out in the note following § 23-74-306.

23-79-111. Standard provisions.

(a) Insurance contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The Insurance Commissioner may waive the required use of a particular provision in a particular insurance policy form if:

(1) He finds the provision unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(2) The policy is otherwise approved by him.

(b) No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the commissioner may approve any substitute provision which, in his opinion, is not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(c) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the commissioner.

(d) The provisions of this section shall not apply to policies issued for large commercial risks.

History. Acts 1959, No. 148, § 278; A.S.A. 1947, § 66-3211; Acts 1999, No. 458, § 5. **Meaning of "this code".** See note to § 23-79-110.

Amendments. The 1999 amendment added (d).

CASE NOTES**Exclusions.**

This section does not preclude a policy clause excluding coverage of bodily injury to the insured and members of his family and household. State Farm Mut. Auto.

Ins. Co. v. Cartmel, 250 Ark. 77, 463 S.W.2d 648 (1971).

Cited: Dodson v. J.C. Penney Co., 336 F.3d 696 (8th Cir. 2003).

23-79-112. Contents.

(a) The written instrument in which a contract of insurance is set forth is the policy.

(b) Every policy shall specify:

(1) The names of the parties to the contract;

(2) The subject of the insurance;

(3) The risks insured against;

(4) The time when the insurance thereunder takes effect and the period during which the insurance is to continue;

(5) The premium or premium deposit;

(6) The policy fee, if any;

(7) The minimum premium to be retained, if any, by a property or casualty insurer in the event of cancellation of the policy by the insured; and

(8) The conditions pertaining to the insurance.

(c) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

(d) Subsections (b) and (c) of this section shall not apply as to surety contracts or to group insurance policies.

(e) All life and accident and health policies and annuity contracts issued by domestic insurers, and the forms thereof filed with the Insurance Commissioner, shall have printed thereon an appropriate designating letter or figure, or combination of letters or figures, or terms identifying the respective forms of policies or contracts, together with the year of adoption of the form. Whenever any change is made in the form, the designating letters, figures, or terms and year of adoption thereon shall be correspondingly changed.

(f)(1) All individual life, annuity, and accident and health policy or contract filings, excluding medicare supplement policies and variable life policies and variable annuities, shall have a notice prominently printed on the first page of the policy or contract stating in substance that the policyholder shall have the right to return the policy or contract within ten (10) days of its delivery, unless the policy or contract provides for a greater period, and to have the premium refunded if after examination of the policy or contract the policyholder is not satisfied for any reason.

(2) If the policyholder returns the policy or contract to the insurance company or to the agent through whom it was purchased within ten (10) days of the policy delivery, it shall be void from its inception, and the parties shall be in the same position as if no policy or contract had been issued.

(g) A policy may contain additional provisions not inconsistent with this code and that are:

(1) Required to be inserted by the laws of the insurer's domicile;

(2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

(3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

(h) On and after January 1, 1990, every property and casualty policy shall contain a provision stating the method to be utilized in computing premium refunds in the event of cancellation of the policy by the insured or the insurer.

(i) The provisions of this section shall not apply to policies issued for large commercial risks.

History. Acts 1959, No. 148, §§ 279, 280; 1981, No. 809, § 14; 1985, No. 804, § 4; A.S.A. 1947, §§ 66-3212, 66-3213; Acts 1989, No. 772, § 17; 1992 (1st Ex.

Sess.), No. 72, § 2; 1999, No. 458, § 6; 2001, No. 1604, §§ 90, 91.

Publisher's Notes. For cumulative effect of 1985 amendment to this section,

see Publisher's Notes to § 23-79-109.

Amendments. The 1999 amendment added (i).

The 2001 amendment substituted "acci-

dent and health" for "disability" in (e) and (f)(1).

Meaning of "this code". See note to § 23-79-110.

RESEARCH REFERENCES

UALR L.J. Survey of Arkansas Law, Insurance, 1 UALR L.J. 210.

Legislative Survey, Insurance, 8 UALR L.J. 587.

Survey, Insurance, 12 UALR L.J. 643.

CASE NOTES

ANALYSIS

Oral contracts.

Premiums and conditions.

Oral Contracts.

There is nothing in the Arkansas statutes that would invalidate an oral contract for life insurance. *Constitution Life Ins. Co. v. M.D. Thompson & Son*, 251 Ark. 784, 475 S.W.2d 165 (1972).

Premiums and Conditions.

Farm bureau membership fees were a prerequisite and not a condition of insurance or a part of the premiums paid to

farm bureau mutual insurance companies where (1) the membership fees were divided between the farm bureaus, a federation of farm bureaus, and the national farm bureau organization, with none of the membership fees going to the mutual insurance companies, (2) county farm bureaus are not in the business of selling insurance, and (3) persons joining farm bureaus join a county farm bureau, rather than a mutual insurance company. *Farm Bureau Policy Holders & Members v. Farm Bureau Mut. Ins. Co.*, 335 Ark. 285, 984 S.W.2d 6 (1998).

23-79-113. Charter or bylaw provisions excluded — Exception.

(a) No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer, other than the subscribers' agreement or power of attorney of a reciprocal insurer, a part of the contract unless the portion is set forth in full in the policy.

(b) Any policy provision in violation of this section shall be invalid.

History. Acts 1959, No. 148, § 281; A.S.A. 1947, § 66-3214.

23-79-114. Entitlement notwithstanding policy provisions — Health services performed by professionals not licensed under Arkansas Medical Practices Act.

(a)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any service provided by persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., the person entitled to

benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under any of the examining boards found in § 17-80-101, as amended by §§ 17-95-301 — 17-95-304.

(2) Nothing in this subsection shall be construed to amend, alter, or repeal any laws relating to the licensing or use of hospitals.

(3) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement in effect prior to February 3, 1971.

(b)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever such a policy, contract, plan, or agreement provides for payment or reimbursement for any service in the vision or human eye field provided by persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., the person entitled to benefits or the person performing services under such a policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for such a service when the service is performed by any person licensed under the Arkansas Optometry Practices Act, § 17-90-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied his or her freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Arkansas Optometry Practices Act, § 17-90-101 et seq., by any insurer or agent or employee of the insurer or by any department, agency, or employee of this state.

(3)(A) Nothing herein shall be construed to enlarge or diminish the practice of optometry as defined by law in the Arkansas Optometry Practices Act, § 17-90-101 et seq., and, in accordance with state law, sole and complete authority regarding determination of those acts, services, procedures, and practices that constitute the practice of optometry in this state shall be vested in the State Board of Optometry.

(B) This section shall specifically include, but not be limited to, authority of the State Board of Optometry to define the parameters of management and comanagement of persons licensed under the Arkansas Optometry Practices Act, § 17-90-101 et seq., in the treatment and management of postoperative and therapeutic care of the human eye.

(4) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement until persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., become entitled to reimbursement for services by the insurer in the vision or human eye field.

(5) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Arkansas Optometry Practices

Act, § 17-90-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service in the vision or human eye field.

(c)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of the diagnosis, medical, mechanical, or surgical treatment of ailments of the human foot provided by persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., the person entitled to benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under the Arkansas Podiatry Practices Act, § 17-96-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Arkansas Podiatry Practices Act, § 17-96-101 et seq., by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of podiatry as defined by law in the Arkansas Podiatry Practices Act, § 17-96-101 et seq.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Arkansas Podiatry Practices Act, § 17-96-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service consisting of the diagnosis, medical, mechanical, and/or surgical treatment of ailments of the human foot.

(d)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services, provided by persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., the person entitled to benefits or persons providing services under the policy, contract, plan, or agreement are entitled to payment or reimbursement on an equal basis for the service when the service is provided by any person licensed as a psychologist under § 17-97-201 et seq. and operating within his or her area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or § 17-97-201 et seq. by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of psychology as defined by law in § 17-97-201 et seq.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or persons licensed as psychologists under § 17-97-201 et seq., shall be entitled to payment or reimbursement on an equal basis for services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services.

(e)(1) Notwithstanding any provision of any accident and health insurance contract or any group accident and health insurance contract or blanket accident and health insurance contract as provided for in this section and §§ 23-79-101 — 23-79-107, 23-79-109 — 23-79-113, 23-79-115 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, benefits shall not be denied thereunder for any health service performed by any person licensed pursuant to the provisions of the Arkansas Dental Practice Act, § 17-82-101 et seq., if the service performed was within the lawful scope of the person's license and the contract would have provided benefits if the service had been performed by a holder of a license issued pursuant to the provisions of the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Arkansas Dental Practice Act, § 17-82-101 et seq., by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of dentistry as defined by the Arkansas Dental Practice Act, § 17-82-101 et seq.

(f)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any anesthesia services provided by persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., the person entitled to benefits or the persons providing services under the policy, contract, plan, or agreement are entitled to the same method of payment for the service when the service is provided by any person licensed as a certified registered nurse anesthetist and operating within his or her area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under § 17-87-302 by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of certified registered nurse anesthetists under § 17-87-302.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or persons licensed as certified registered nurse anesthetists under § 17-87-302 shall be entitled to the same method of payment for anesthesia services.

(g)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever the policy, contract, plan, or agreement provides for payment or reimbursement for any service in the audiology field provided by persons licensed as audiologists under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., the person entitled to benefits or the person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed as an audiologist under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied his or her freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., by any insurer or agent or employee of the insurer or by any department, agency, or employee of this state.

(3)(A) Nothing in this subsection shall be construed to enlarge or diminish the practice of audiology as defined under § 17-100-103.

(B) Under state law, sole and complete authority regarding determination of those acts, services, procedures, and practices that may be reimbursed on an equal basis shall be vested in the Board of Examiners in Speech-Language Pathology and Audiology.

(C) This section shall specifically include, but not be limited to, the authority of the board to define the parameters of management and comanagement of persons licensed under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., in the treatment and management of hearing and disorders of hearing.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq., or the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service in the audiology field.

History. Acts 1959, No. 148, § 279; § 1; 1993, No. 1271, § 1; 2001, No. 1604, 1971, No. 34, §§ 1-3; 1971, No. 531, §§ 1-5; 1975, No. 303, §§ 1-4; 1975, No. 741, § 92; 2003, No. 1455, § 2.

Amendments. The 2001 amendment, in (e)(1), substituted “any accident” for “any health or accident,” and substituted “accident and health” for “disability.” The 2003 amendment added (g).

RESEARCH REFERENCES

UALR L.J. Survey of Arkansas Law, Insurance, 1 UALR L.J. 210.

Legislative Survey, Insurance, 8 UALR L.J. 587.

23-79-115. Entitlement notwithstanding policy provisions — Services performed by outpatient centers.

(a)(1) Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any health care service provided by hospitals or related facilities as defined in § 20-9-201 or § 20-10-213, the person entitled to payment or reimbursement for services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient surgery centers under §§ 20-9-214 and 20-9-215.

(2) This subsection applies to insurance policies and hospital service corporation contracts that are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 6, 1977, and to such other contracts, plans, or agreements that are entered into or effectuated in this state more than one hundred twenty (120) days after July 6, 1977.

(b)(1) Notwithstanding any provisions of any individual or group accident and health insurance policy, or any provision of a policy, contract, plan, or agreement covering hospital or medical services, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any health care service provided by hospitals or related facilities as defined in § 20-9-201 or § 20-10-213, the person entitled to payment or reimbursement or services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is provided by facilities licensed as outpatient psychiatric centers under §§ 20-9-214 and 20-9-215.

(2) This subsection applies to insurance policies and hospital service corporation contracts that are delivered or issued for delivery in this state more than one hundred twenty (120) days after July 20, 1979, and to such other contracts, plans, or agreements that are entered into or effectuated in this state more than one hundred twenty (120) days after July 20, 1979.

History. Acts 1959, No. 148, § 279; 1977, No. 232, § 1; 1979, No. 803, § 1; A.S.A. 1947, § 66-3212; Acts 2001, No. 1604, §§ 93, 94.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (a)(1) and (b)(1).

RESEARCH REFERENCES

UALR L.J. Legislative Survey, Insurance, 8 UALR L.J. 587.

23-79-116. Execution.

(a) Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative authorized by the insurer.

(b) A facsimile signature of any executing individual may be used in lieu of an original signature.

(c) No insurance contract which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

History. Acts 1959, No. 148, § 282; A.S.A. 1947, § 66-3215.

CASE NOTES

Oral Contract.

There is nothing in the Arkansas statutes that would invalidate an oral con-

tract for life insurance. *Constitution Life Ins. Co. v. M.D. Thompson & Son*, 251 Ark. 784, 475 S.W.2d 165 (1972).

23-79-117. Underwriters' and combination policies.

(a)(1) Two (2) or more authorized insurers may jointly issue and shall be jointly and severally liable on an underwriters' policy bearing their names.

(2) Any one (1) insurer may issue policies in the name of an underwriter's department, and the policy shall plainly show the true name of the insurer.

(b) With the approval of the Insurance Commissioner, two (2) or more insurers may issue a combination policy which shall contain provisions substantially as follows:

(1) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage according to the terms of the policy, or for specified percentages or amounts thereof aggregating the full amount of insurance under the policy; and

(2) That service of process or of any notice or proof of loss required by the policy upon any of the insurers executing the policy shall constitute service upon all the insurers.

(c) This section shall not apply to cosurety obligations.

History. Acts 1959, No. 148, § 283;
A.S.A. 1947, § 66-3216.

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992 Insurance Law Decisions, 1992 Ark. L. Notes 85.

CASE NOTES

Applicability.

The specific provisions of the Arkansas Surplus Lines Insurance Law control over

this section. *Arkansas-Oklahoma Gas Corp. v. Lukis Stewart Price Forbes & Co.*, 306 Ark. 425, 816 S.W.2d 571 (1991).

23-79-118. Noncomplying forms.

Any insurance policy, rider, or endorsement issued and otherwise valid which contains any condition or provision not in compliance with the requirements of this code shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had the policy, rider, or endorsement been in full compliance with this code.

History. Acts 1959, No. 148, § 284;
A.S.A. 1947, § 66-3217.

Meaning of "this code". See note to § 23-79-110.

23-79-119. Construction of policies.

(a) Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made a part of the policy.

(b) All insurance contracts which are issued for specific terms and which may be renewed for subsequent terms at the option of the insured or the insurer shall be construed from and after their respective dates of renewal as being new contracts to the extent of having incorporated therein all applicable public policy which by statute or regulation may have become applicable to such contracts in the interval between:

(1) Original issuance or last renewal; and

(2) The renewal following the newly applicable statement of public policy.

(c)(1) Except as provided in this subsection, a health insurance issuer that provides individual health insurance coverage for major medical benefits to an individual shall renew or continue in force such coverage at the option of the individual.

(2) **GENERAL EXCEPTIONS.** A health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following:

(A) **NONPAYMENT OF THE PREMIUM.** The individual has failed to pay premiums or contributions in accordance with the terms of the health

insurance coverage or the issuer has not received timely premium payments;

(B) FRAUD. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(C) TERMINATION OF THE PLAN. The issuer is ceasing to offer major medical coverage in the individual market in accordance with applicable state or federal law;

(D) MOVEMENT OUTSIDE THE SERVICE AREA. In the case of a health insurance issuer that offers health insurance for major medical coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the issuer is authorized to do business, but only if the individual major medical coverage is terminated under this subdivision (c)(2)(D) uniformly without regard to any health-status related factor of covered individuals; and

(E) ASSOCIATION MEMBERSHIP CEASES. In the case of health insurance for major medical coverage that is made available in the individual market only through one (1) or more bona fide associations, the membership of the individual in the association, as the basis on which the coverage is provided, ceases but only if such major medical coverage is terminated under this subdivision (c)(2)(E) uniformly without regard to any health status-related factor of covered individuals.

(3) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE—PARTICULAR TYPE OF COVERAGE NOT OFFERED. In the case in which an insurer decides to discontinue offering a particular type of health insurance providing major medical coverage offered to the individual market, coverage of such a type may be discontinued by the issuer only if:

(A) The issuer provides to each covered individual with coverage of this type in the market notice of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

(B) The issuer offers to each individual in the individual market with coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in the market; and

(C) In exercising the option to discontinue coverage of this type, and in offering the option of coverage under subdivision (c)(3)(B) of this section, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(4) DISCONTINUANCE OF SUCH COVERAGE—IN GENERAL. Subject to the provisions of this subsection, in any case in which a health insurance issuer elects to discontinue offering all health insurance providing major medical coverage in the individual market in this state, health insurance coverage may be discontinued by the issuer only if the issuer provides to the Insurance Commissioner and to each individual notice of such discontinuance at least one hundred eighty (180) days prior to the date of expiration of the coverage.

(5) **PROHIBITION ON MARKET REENTRY.** In the case of a discontinuation in the individual market under this subsection, the issuer may not provide for the issuance of any health insurance providing major medical coverage in the market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(6) **EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.** At the time of coverage renewal, a health insurance issuer may modify the health insurance providing major medical coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

(7) **APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.** In applying this subsection in the case of health insurance providing major medical coverage that is made available by a health insurance issuer in the individual market only through one (1) or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

(8) For purposes of this subsection, the terms or phrases "health insurance issuer", "health insurance coverage" or "coverage", "Insurance Commissioner", "network plan", "health status-related factor", "bona fide association", "individual market", and "eligible individual" shall be defined pursuant to the definitions contained in § 23-86-303.

History. Acts 1959, No. 148, § 285; 1981, No. 520, § 1; A.S.A. 1947, § 66-3218; Acts 1993, No. 901, § 40; 1999, No. 881, § 13.

Amendments. The 1999 amendment added (c).

CASE NOTES

Contract.

Insurance contract between the parties was set out in both the printed policy and the application where policy contained a paragraph which stated that "The consideration for this policy is the application, a copy of which is attached to and made a part of the policy, and the payment of the

required premiums" and that contained the statement, "This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance" and the application was physically attached to the printed policy. *American Pioneer Life Ins. Co. v. Allender*, 18 Ark. App. 234, 713 S.W.2d 249 (1986).

23-79-120. Binders.

(a) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(b) No binder shall be valid beyond the issuance of the policy with respect to which it was given, or beyond ninety (90) days from its effective date, whichever period is the shorter.

(c) If the policy has not been issued, a binder may be extended or renewed beyond the ninety (90) days with the written approval of the Insurance Commissioner or in accordance with such rules and regulations relative thereto as the commissioner may promulgate.

(d) This section shall not apply to life insurance or accident and health insurance.

History. Acts 1959, No. 148, § 286; A.S.A. 1947, § 66-3219; Acts 2001, No. 1604, § 95.

Amendments. The 2001 amendment

substituted "insurance or accident and health insurance" for "or disability insurances" in (d).

CASE NOTES

ANALYSIS

Agents.

Lapse of temporary insurance.

Terms.

Agents.

Where one determined to be an authorized representative of an insurance agency represented that insurance was transferred, the insurance company was liable to the transferee. *Home Ins. Co. v. Crawford*, 251 Ark. 843, 475 S.W.2d 889 (1972).

Lapse of Temporary Insurance.

Where, after the lapse of the temporary insurance, there was no evidence before the court that other insurance was unavailable to the debtor, the court would not invoke its equitable powers under 11 U.S.C. § 105(a) to indefinitely enjoin the insurance company from cancelling coverage, except for a period to allow the debtor to secure other insurance coverage. *United States Fid. & Guar. Co. v. Hilyard*

Drilling Co., 58 Bankr. 616 (Bankr. W.D. Ark. 1985).

Terms.

A written insurance policy for "all-risk" coverage which was issued after the loss had occurred and excluded coverage for cargoes of liquor did not mean that an oral binder included the same exclusion absent a showing that it was the policy of all inland-marine carriers to exclude coverage for liquor in "all-risk" policies or absent a showing that insured was aware that an "all-risk" policy carried certain cargo exclusions. *Hilt Truck Lines v. Riggins*, 756 F.2d 676 (8th Cir. 1985).

Until the time the insurance policy is issued, this section supplies the terms of the policy. *United States Fid. & Guar. Co. v. Hilyard Drilling Co.*, 58 Bankr. 616 (Bankr. W.D. Ark. 1985).

Cited: *Leigh Winham, Inc. v. Reynolds Ins. Agency*, 279 Ark. 317, 651 S.W.2d 74 (1983); *Argenia, Inc. v. Blasingame*, 51 Ark. App. 70, 910 S.W.2d 225 (1995).

23-79-121. Delivery of policy.

(a) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled to receive it, within a reasonable period of time after its issuance, except when a condition required by the insurer has not been met.

(b)(1) In the event the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any property or motor vehicle and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to the property or vehicle is insured, then a duplicate of the policy, or a certificate of insurance setting forth the name and address of the insurer, insurance classification in the case of a vehicle, type of coverage, limits of liability,

premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same information, shall be delivered by the agent through whom the insurance was procured to each vendee, mortgagor, or pledgor named in the policy.

(2) No insurer shall have any responsibility or liability with respect to compliance or noncompliance with any requirement of this subsection.

(3) This subsection does not apply to insurance of aircraft.

History. Acts 1959, No. 148, § 287;
A.S.A. 1947, § 66-3220.

CASE NOTES

Life Insurance.

There is nothing in the Arkansas statutes that would invalidate an oral con-

tract for life insurance. *Constitution Life Ins. Co. v. M.D. Thompson & Son*, 251 Ark. 784, 475 S.W.2d 165 (1972).

23-79-122. Negotiability of premium notes.

(a)(1) No note given for premiums on insurance in this state shall be negotiated until the policy for which the note was given has been issued and delivered to the maker of the note, and all notes so given shall state the purpose for which the note was given.

(2) However, this subsection shall not be applicable in cases in which the policy is issued or approved in the form and at the rate applied for and the coverage is effective prior to the issuance or approval.

(b) Nothing in this section shall be construed in any way to invalidate these notes between the payee and payor, and notes when they become negotiable shall in all respects be as other negotiable paper.

History. Acts 1959, No. 148, § 288;
A.S.A. 1947, § 66-3221.

CASE NOTES

ANALYSIS

Purpose.

Holder in due course.

Purpose.

The purpose of former similar section was to prevent irresponsible insurance companies and irresponsible agents of insurance companies from realizing on obligations for insurance by applicants before

delivery of the policy. *People's Sav. Bank v. Raines*, 175 Ark. 1155, 2 S.W.2d 20 (1928) (decision under prior law).

Holder in Due Course.

After note becomes negotiable and is held by innocent holder in due course, maker may be estopped to deny delivery of policy. *People's Sav. Bank v. Raines*, 175 Ark. 1155, 2 S.W.2d 20 (1928) (decision under prior law).

23-79-123. Renewal by certificate.

(a) Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer upon a currently authorized policy form and at the premium rate then required for that type of policy, for

a specific additional period or periods by certificate or by endorsement of the policy and without requiring the issuance of a new policy.

(b) By reasonable rules and regulations, or by order, the Insurance Commissioner may deny the use of such certificates for renewal of such types of policies or in such circumstances as may be necessary or advisable to protect insureds who may otherwise hold forms of policies which no longer contain all of the benefits or conditions applicable under similar policies currently issued by the same insurer.

(c) The provisions of this section shall not apply to policies issued for large commercial risks.

History. Acts 1959, No. 148, § 289; A.S.A. 1947, § 66-3222; Acts 1999, No. 458, § 7. **Amendments.** The 1999 amendment added (c).

23-79-124. Assignment.

(a) A policy may be assignable or not assignable, as provided by its terms.

(b) Subject to its terms relating to assignability, any life or accident and health policy, under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned, either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer.

(c) Any assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

History. Acts 1959, No. 148, § 290; A.S.A. 1947, § 66-3223; Acts 2001, No. 1604, § 96. **Amendments.** The 2001 amendment substituted "accident and health" for "disability" in (b).

CASE NOTES

Cited: American Medical Int'l, Inc. v. Arkansas Blue Cross & Blue Shield, 299 Ark. 514, 773 S.W.2d 831 (1989).

23-79-125. Payment by insurer — Discharge.

(a) Whenever the proceeds of or payments under a life or accident and health insurance policy or annuity contract become payable in accordance with the terms of the policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment of the amount in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by the assignment as being

entitled to the benefits shall be entitled to receive the proceeds or payments and to give full acquittance therefor.

(b) The payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that the other person claims to be entitled to the payment or some interest in the policy or contract.

History. Acts 1959, No. 148, § 291; A.S.A. 1947, § 66-3224; Acts 2001, No. 1604, § 97.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (a).

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992

Insurance Law Decisions, 1992 Ark. L. Notes 85.

CASE NOTES

Discharge.

Absent written notice, insurer's payment of proceeds to the beneficiaries would have fully discharged it from all claims under the policy; therefore, because insurer opted to file an interpleader,

rather than take advantage of its statutory protections under this section, it should bear the responsibility of the additional expenses visited on the beneficiaries. *USable Life v. Fow*, 307 Ark. 379, 820 S.W.2d 453 (1991).

23-79-126. Forms for proof of loss.

(a) An insurer shall furnish to any person claiming to have a loss under an insurance contract issued by the insurer forms of proof of loss for completion by the person, within twenty (20) days after a loss has been reported to the insurer, but the insurer shall not, by reason of the requirement to furnish forms, have any responsibility for or with reference to the completion of the proof or the manner of completion or attempted completion.

(b) However, failure of an insurer to furnish the forms of proof of loss within twenty (20) days after a loss has been reported to the insurer shall constitute a waiver of proof of loss requirements, and the insurer may not thereafter require a proof of loss.

(c) Further, the provisions of this section shall not be applicable to health, accident, or life insurers.

History. Acts 1959, No. 148, § 292; 1977, No. 885, § 1; 1979, No. 768, § 1; A.S.A. 1947, § 66-3225.

RESEARCH REFERENCES

UALR L.J. Strother, Survey of Insurance Law, 3 UALR L.J. 242.

23-79-127. Claims administration by insurer not waiver.

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

- (1) Acknowledgment of the receipt of notice of loss or claim under the policy;
- (2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted; or
- (3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any loss or claim, except that investigating and negotiations may constitute a waiver of proof of loss requirements.

History. Acts 1959, No. 148, § 293;
A.S.A. 1947, § 66-3226.

23-79-128. Right to insure spouse's life.

(a)(1) It shall be lawful for any married woman, by herself and in her name, or in the name of any third person, with his or her assent as her trustee, to cause to be insured, for her sole use, the life of her spouse for any definite period or for the term of his natural life.

(2) In case of her surviving her spouse, the sums or net amount of the insurance becoming due and payable by the terms of the insurance shall be payable to her and for her use.

(3) In case of death of the wife before the decease of her spouse, the amount of the insurance may be made payable to his or her children for their use, and to their guardian for them, if they are under age, as is provided in the policy of insurance.

(4)(A) All proceeds and avails of the insurance shall be free from the claims of the representatives of the spouse or of any of his creditors, whether or not the right to change the beneficiary is reserved or permitted.

(B) However, subject to the statute of limitations, the amount of any premiums for the insurance paid out of the funds or property of the spouse with intent to defraud creditors, including interest thereon, shall enure to their benefit from the proceeds of the policy, but the company issuing the policy shall be discharged of all liability on the policy by payment of its proceeds in accordance with its terms, unless, before such a payment, the company shall have written notice by or in behalf of a creditor of a claim to recover for premiums paid with intent to defraud creditors with specifications of the amount claimed.

(b) This section shall not be deemed to give the wife any present or vested interest in any policy of life insurance insuring the life of her spouse unless the wife is the owner in fact of the policy, either directly

or through her expressly designated trustee, or unless otherwise provided in the policy.

(c) The provisions of this section shall also govern insurance procured on the life of a wife by her spouse.

History. Acts 1959, No. 148, § 294; A.S.A. 1947, § 66-3227; Acts 2001, No. 1604, § 98.

Amendments. The 2001 amendment

redesignated former (a) as present (a)(1)-(4) and made related changes; added (c); and made gender neutral changes throughout.

CASE NOTES

ANALYSIS

Bankruptcy of husband.

Debts of wife.

Pledge of policy.

Bankruptcy of Husband.

The cash surrender value of life insurance policies payable to the bankrupt insured's wife was exempt from the claims of creditors. *In re Erstine*, 41 F.2d 559 (E.D. Ark. 1930) (decision under prior law).

The cash surrender value of life policies naming the bankrupt's wife as beneficiary was held not an asset of the bankrupt's estate notwithstanding the bankrupt reserved the right to change the beneficiary. *In re Miller*, 74 F.2d 86 (8th Cir. 1934) (decision under prior law).

Debts of Wife.

A bank deposit by a widow of the proceeds of her husband's life policy was not exempt from garnishment on a judgment against her. *Peters v. Goodwin*, 190 Ark. 24, 76 S.W.2d 980 (1934); *Ponder v. Jefferson Std. Life Ins. Co.*, 201 Ark. 179, 143 S.W.2d 1115 (1940) (decision under prior law).

Pledge of Policy.

Oral pledge of life insurance policy as security for note, without consent of insured's wife who was beneficiary therein and had possession thereof, was invalid. *Strickland v. Dyer*, 192 Ark. 462, 92 S.W.2d 206 (1936) (decision under prior law).

Cited: *Casteel v. Cont'l Cas. Co.*, 273 F.3d 1142 (8th Cir. 2001).

23-79-129. Coverage of newborn infants.

(a)(1) Every accident and health insurance policy, contract, certificate, or health care plan sold, delivered, issued, or offered for sale, issue, or delivery in this state, other than coverage limited to expenses from accidents or specified diseases, whether an individual or group policy, contract, certificate, or plan that covers the insured and members of the insured's family, shall include coverage for newborn infant children by the insured from the moment of birth.

(2) The coverage of newborn children shall be the same as is provided for other members of the insured's family and shall include:

(A) Coverage for illness, injury, congenital defects, and premature birth;

(B) Coverage for tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and

(C) Subject to minimum benefits required by § 23-99-404, coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until

the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

(b) The insurer may require that the insured give notice to his or her insurer of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

(c) The Insurance Commissioner shall not approve any policy or contract to be sold, issued, or offered for sale in this state unless it shall specifically include the coverage required in this section for newborn infants.

History. Acts 1975, No. 298, §§ 1-3; 1981, No. 481, § 3; 1983, No. 357, § 1; 1983, No. 522, § 27; A.S.A. 1947, §§ 66-3248 — 66-3250; Acts 1987, No. 456, § 15; 1987, No. 573, § 3; 1987 (1st Ex. Sess.) No. 12, § 1; 1987 (1st Ex. Sess.) No. 60, § 1; 1995, No. 113, § 2; 2001, No. 1604, § 99; 2003, No. 1293, § 3.

Publisher's Notes. Acts 1975, No. 298, § 2, provided that the provisions of this section apply to all policies, contracts, or plans sold, delivered, issued or offered for sale, delivery, or issue after July 1, 1975. It further provided that policies or contracts issued before that date were subject to this section and would automatically include the required coverage beginning with the first renewal or anniversary date after July 1, 1975.

Acts 1983, No. 357, § 1, provided in part that all existing group contracts, including those issued by hospital and medical service corporations, were to conform to this section upon the first anniversary of the issue date occurring after July 4, 1983.

Acts 1983, No. 522, § 51, provided, in part, that the act would be cumulative of

prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Acts 1987, No. 60, was vetoed by the Governor. However, such veto was held invalid by the Attorney General (Opinion No. 87-241) on the grounds that the veto occurred after the expiration of the twenty-day period allowed by Ark. Const., Art. 6, § 15. Accordingly, the act became law on June 26, 1987.

Amendments. The 2001 amendment redesignated former (a) as present (a)(1) and (a)(2) and made related changes; substituted "accident and health" for "disability" in (a)(1); and inserted "subject to minimum benefits required by § 23-99-404" in (a)(2).

The 2003 amendment, in (a)(2)(B), substituted "galactosemia, sickle-cell anemia ...State of Arkansas" for "and galactosemia and in the case of non Caucasian newborn infants, tests for sickle-cell anemia" in (a)(2)(B); and made minor stylistic changes.

CASE NOTES

Children.

This section does not extend coverage to an insured's grandchild born to his unmarried daughter from the moment of birth; the word "children" as used in this

section means only descendants of the first degree. *Lane v. Arkansas Blue Cross & Blue Shield, Inc.*, 285 Ark. 337, 686 S.W.2d 438 (1985).

23-79-130. Group policies — Offer of coverage for impairment of speech or hearing.

(a) Every insurer which offers for sale, issue, or delivery in this state, any group insurance policy, contract, plan, or agreement for health and accident or medical service or indemnity which covers the insured and members of the insured's family, shall offer coverage for the necessary care and treatment of loss or impairment of speech or hearing, subject

to the same durational limits, dollar limits, deductibles, and coinsurance factors as other covered services in the policies or contracts.

(b) The offer of benefits under subsection (a) of this section shall be in writing by offering a rider to the group administrator.

(c) Nothing in this section shall prohibit the insurance company or not-for-profit health service corporation from including any coverage for loss or impairment of speech, language, or hearing as standard coverage in their policies or contracts.

(d) The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

(e) The additional coverage provided for in this section shall not apply to hearing instruments or devices.

History. Acts 1985, No. 303, §§ 1, 4; A.S.A. 1947, §§ 66-3260, 66-3263.

Publisher's Notes. Acts 1985, No. 303, § 2, provided that the group administrators of group insurance policies, contracts, plans, or agreements for health and accident or medical service or indemnity in effect on July 1, 1985, must be offered the

coverage provided in this section no later than August 1, 1985, and the offer would be valid until October 1, 1985. Section 3 of the act provided that if any group administrator did not accept the rider offered for the additional coverage that action would not affect the coverage under the group policy, contract, plan, or agreement.

23-79-131. Exemption of proceeds — Life insurance.

(a)(1) If a policy of insurance is effected by any person on his or her own life or on another life in favor of a person other than himself or herself or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to the person, the lawful beneficiary or assignee of the policy, other than the insured or the person effecting the insurance or executors or administrators of the insured or the person effecting the insurance, shall be entitled to its proceeds and avails against the creditors and representatives of the insured and those of the person effecting the policy whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable to the person whose life is insured, if the beneficiary or assignee shall predecease such a person.

(2) However, subject to the statute of limitations, the amount of any premiums for the insurance paid with intent to defraud creditors, including interest thereon, shall enure to their benefit from the proceeds of the policy, but the insurer issuing the policy shall be discharged of all liability thereof by payment of its proceeds in accordance with its terms unless, before the payment, the insurer shall have written notice at its home office, by or in behalf of a creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specifications of the amount so claimed.

(b) For the purposes of subsection (a) of this section, a policy shall also be deemed to be payable to a person other than the insured if, and

to the extent that, a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by the clause.

History. Acts 1959, No. 148, § 295; efits of mutual benefit insurers, § 23-72-114.
A.S.A. 1947, § 66-3228.

Cross References. Exemption of ben-

CASE NOTES

ANALYSIS

Beneficiary's creditors.
Participation in proceeds.

Beneficiary's Creditors.

A bank deposit by a widow of the proceeds of her husband's life policy was not exempt from garnishment on a judgment against her. *Peters v. Goodwin*, 190 Ark. 24, 76 S.W.2d 980 (1934) (decision under prior law).

Participation in Proceeds.

If former similar section changed the law of Arkansas with respect to the rights of creditors of the insured, which was doubtful, it limited creditors to the recovery of an amount, from the proceeds of his policies, equal to such premiums as had been wrongfully diverted by him from

funds which should have been paid upon his debts. *Spiro State Bank v. Bankers' Nat'l Life Ins. Co.*, 69 F.2d 185 (8th Cir. 1934), cert. denied, 305 U.S. 612, 59 S. Ct. 71, 83 L. Ed. 390 (1938), rehearing denied, 305 U.S. 671, 59 S. Ct. 142, 83 L. Ed. 435 (1938) (decision under prior law).

Where a person procures an insurance policy for the benefit of himself or his executors or administrators, his creditors are not prohibited from participating therein; but if effected for the benefit of some other lawful beneficiary, the creditors are prohibited from participating in the proceeds thereof. *Lee v. Potter*, 193 Ark. 401, 100 S.W.2d 252 (1937) (decision under prior law).

Cited: *Woolsey v. Nationwide Ins. Co.*, 884 F.2d 381 (8th Cir. 1989).

23-79-132. Exemption of proceeds — Group life.

(a)(1) A policy of group life insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of the insured individual, or his or her beneficiary, or of any other person having a right under the policy.

(2) The proceeds of the policy, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his or her debts.

(b) This section shall not apply to group life insurance issued pursuant to § 23-83-106 to a creditor covering his or her debtors to the extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

History. Acts 1959, No. 148, § 296;
A.S.A. 1947, § 66-3229.

23-79-133. Exemption of proceeds — Accident and health insurance.

The proceeds or avails of all contracts of accident and health insurance and of provisions providing benefits on account of the insured's disability that are supplemental to life insurance or annuity contracts shall be exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use.

History. Acts 1959, No. 148, § 297; A.S.A. 1947, § 66-3230; Acts 2001, No. 1604, § 100.

Amendments. The 2001 amendment substituted "accident and health" for "disability."

23-79-134. Exemption of proceeds — Annuity contracts — Assignability of rights.

(a) Benefits, rights, privileges, and options under any annuity or variable annuity contract, which are due or prospectively due the annuitant, shall not be subject to execution, attachment, or garnishment, nor shall the annuitant be compelled to exercise the rights, powers, or options under the contract, nor shall creditors be allowed to interfere with or terminate the contract except:

(1) As to amounts paid for any annuity or variable annuity with intent to defraud creditors, including interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of payments to the annuitant out of which the creditor seeks to recover. The notice shall specify the amount claimed, or such facts as will enable the insurer to ascertain the amount, and shall set forth such facts as will enable the insurer to ascertain the insurance or annuity contract, the person insured or annuitant, and the payments sought to be avoided on the ground of fraud; and

(2) If the total benefits presently due and payable to any annuitant under all annuity contracts under which he or she is an annuitant shall at any time exceed the exemptions granted an annuitant by law, a court of appropriate jurisdiction may order the annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of the excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his or her family, if dependent upon him or her, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(b) If the contract so provides, the benefits, rights, privileges, or options accruing under the contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and, if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained in this section for the annuitant shall apply with respect to the beneficiary or assignee.

(c) An "annuity contract" within the meaning of this section shall be any obligation to pay certain sums at stated times, during life or lives,

or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one (1) or more persons jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives or for a specified term or terms.

(d) A "variable annuity" contract within the meaning of this section shall be any obligation to pay sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one (1) or more persons jointly or otherwise, where the sums payable vary directly according to investment experience with respect to the variable annuity contract, but does not include annuity contracts or payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

History. Acts 1959, No. 148, § 298; 1965, No. 460, § 2; A.S.A. 1947, § 66-3231.

RESEARCH REFERENCES

Ark. L. Notes. Laurence, Recent Developments in the Arkansas Law of Garnishment: A Compendium of the Pertinent Cases and Statutes, 1992 Ark. L. Notes 39.

Laurence, On Worthen, Walker and Dicta: The Supreme Court Shoots the

Breeze About Exemption Law, 1993 Ark. L. Notes 73.

Laurence, Recent Developments in the Arkansas Law of Garnishment: Does a Corporate Garnishee Need a Lawyer to Answer the Writ?, 1997 Ark. L. Notes 95.

CASE NOTES

Prohibition Against Garnishment.

The provisions of subsection (a) and § 24-7-715(a) are not personal property exemptions that can only be asserted and scheduled by the debtor; instead, these prohibitions against garnishment can be raised as an affirmative defense by garnishees. Walker v. Walker, 303 Ark. 34, 791 S.W.2d 710 (1990).

The provisions of subsection (a) and § 24-7-715(a) are not absolute personal

exemptions like those contemplated by Ark. Const., Art. 9, §§ 1 and 2. Walker v. Walker, 303 Ark. 34, 791 S.W.2d 710 (1990).

Subsection (a) and § 24-7-715(a) do not conflict with the personal exemption provisions provided under Ark. Const., Art. 9, § 1. Walker v. Walker, 303 Ark. 34, 791 S.W.2d 710 (1990).

23-79-135. Prompt payment of certain claims required.

In any case in which an insured under any hospital, medical, or surgical policy or plan, or any accident policy, becomes entitled to benefits thereunder in an amount of three hundred dollars (\$300) or less and the company, association, or organization, except governmental or nonprofit organizations, issuing the policy or plan denies liability or fails to pay benefits within a reasonable time after demand is made therefor by the insured or member, then the company, association, or organization shall be liable to the insured for the benefits, and, in

addition thereto, a penalty in an amount equal to benefits to which the insured is found to be entitled.

History. Acts 1965, No. 419, § 1;
A.S.A. 1947, § 66-3243.

23-79-136. Agreement for insurer to invest premium prohibited.

(a) It is unlawful for any insurance company authorized to do business in this state to issue or offer for sale or issue in this state any policy of insurance under which the insurer agrees to invest a portion of the policy premium, whether for one (1) or more years, and hold a portion of the policy premium for investment in its own name either directly or indirectly, or as trustee for the benefit of the insured or for the benefit of a certain class of policyholders.

(b) Any insurance company issuing or offering to issue any policy in violation of the provisions of subsection (a) of this section shall be fined in any sum not less than five hundred dollars (\$500) nor more than five thousand dollars (\$5,000), and in addition, the authority of the insurance company to do business in this state may be revoked.

(c)(1) This section shall not be construed to prohibit the offer or sale of a variable annuity contract issued, or variable benefit payable, in compliance with the applicable requirements of the Arkansas Insurance Code, the Securities Act of 1933, the Investment Company Act of 1940, and the Arkansas Securities Act, § 23-42-101 et seq.

(2) This section shall not apply to contracts with respect to amounts maintained by insurers in such group pension, profit-sharing, and annuity separate accounts as may be authorized by law.

(3) This section shall not apply to policy provisions permitting benefits to be left on deposit with the insurer at a specified rate of interest.

History. Acts 1967, No. 185, §§ 1-3;
A.S.A. 1947, §§ 66-3245 — 66-3247.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

U.S. Code. The Securities Act of 1933, referred to in this section, is codified as 15 U.S.C. § 77a et seq. The Investment Company Act of 1940 is codified as 15 U.S.C. § 80a-1 et seq.

23-79-137. Coverage for adopted minors.

(a) Every accident and health insurance policy, self-insured health plan, hospital and medical service contract, contract, certificate, or health care plan sold, delivered, issued, or offered for sale, issue, or delivery in this state, whether an individual or group policy, contract, or plan, that covers the insured and members of the insured's family shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family.

(b) The coverage required by this section shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage required by this section shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.

(c) The coverage required by this section shall terminate upon the dismissal or denial of a petition for adoption.

History. Acts 1987, No. 99, § 1; 2001, No. 1604, § 101.

Publisher's Notes. Acts 1987, No. 99, § 2, provided that the provisions of this act shall apply to all policies, contracts, or plans sold, delivered, issued, or offered for sale, delivery, or issue on or after July 1, 1987, and that all policies or contracts issued prior to July 1, 1987, shall be

subject to the provisions of this act and shall automatically include the coverage required by this act beginning with the first renewal or premium anniversary date occurring on or after July 1, 1987.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (a).

23-79-138. Information to accompany policies.

(a) Every policy of life insurance, accident and health insurance, property insurance, or casualty insurance issued after January 1, 1988, and covering risks located, resident, or to be performed in the State of Arkansas shall be accompanied by the following information:

(1) The complete address and telephone number, 800 number if possible, of the policyholder's service office of the company issuing the policy;

(2) The name, address, and telephone number of the agent soliciting the policy, if applicable; and

(3) The address and telephone number, 800 number if available, of the State Insurance Department.

(b) Any person who fails to comply with the provisions of this section shall be subject to the penalties provided in § 23-60-108.

(c) The Insurance Commissioner is authorized to adopt appropriate rules and regulations to enforce and carry out the intent and purposes of this section.

History. Acts 1987, No. 197, §§ 1-3; 2001, No. 1604, § 102.

Amendments. The 2001 amendment, in the introductory language of (a), substi-

tuted "accident and health" for "disability," and deleted "including accident and health" preceding "property insurance."

23-79-139. Benefits for alcohol or drug dependency treatment.

(a)(1) Every insurer, hospital and medical service corporation, and health maintenance organization transacting accident and health insurance in this state shall offer and make available under all group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service, or prepaid basis benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to

the same durational limits, dollar limits, deductibles, and coinsurance factors, except as provided in this section.

(2)(A) The offer for these benefits shall be subject to the right of the policy or contract holder to reject the coverage or select any alternative level of benefits.

(B) The rejection by the policy or contract holder shall be in writing.

(b) Any benefits provided under alcohol or drug dependency coverage shall be determined as necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital.

(c) Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.

(d) The facility or unit may be:

(1) A unit within a general hospital or an attached or freestanding unit of a general hospital;

(2) A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital; or

(3) A freestanding facility specializing in treatment of persons who are substance abusers or are alcohol or drug dependent, and may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse facilities", "social setting detoxification facilities", and "medical detoxification facilities", or by other names if the purpose is to provide treatment of alcohol or drug dependent or substance abusing persons, but shall not include halfway houses or recovery farms.

(e) Every policy or contract of insurance that provides benefits for alcohol or drug dependency treatment and that provides total annual benefits for all illnesses in excess of six thousand dollars (\$6,000) is subject to the following conditions:

(1) The policy or contract shall provide, for each twenty-four-month period, a minimum benefit of six thousand dollars (\$6,000) for the necessary care and treatment of alcohol or drug dependency;

(2) No more than one-half ($\frac{1}{2}$) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and

(3) The policy or contract shall provide a minimum benefit of twelve thousand dollars (\$12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.

(f) For the purposes of this section, the term "alcohol or drug dependency treatment facility" shall mean a public or private facility, or unit in a facility, that is engaged in providing treatment twenty-four (24) hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician, and that is also properly licensed or accredited to provide those services by the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health.

(g) Nothing in this section shall prohibit any certificate or contract from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for alcohol or drug dependency.

(h) As used in this section, “alcohol or drug dependency” means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

(i) This section shall apply to group policies or contracts delivered or issued for delivery or renewed in this state after November 17, 1987, but shall not apply to blanket short-term travel accident only, limited or specified disease, conversion policies or contracts, nor to policies or contracts referred to as medicare supplement policies, designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act.

History. Acts 1987, No. 1047, §§ 1-6; 2001, No. 1604, § 103.

Amendments. The 2001 amendment substituted “accident and health” for “health, accident, or disability” in (a)(1).

U.S. Code. Title XVIII of the Social Security Act referred to in this section is codified as 42 U.S.C. § 1395 et seq.

23-79-140. Mammograms.

(a)(1) “Mammography” means radiography of the breast.

(2) “Screening mammography” is a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician’s interpretation of the results of the procedure.

(3) “Diagnostic mammography” is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the physician interpreting the study, and additional views are obtained as needed. A physical examination of the breast by the interpreting physician to correlate the radiologic findings is often performed as part of the study.

(b) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider in the State of Arkansas shall offer, after January 1, 1990, to each master group contract holder as an optional benefit, coverage for at least the following mammogram screening of occult breast cancer:

(1) A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;

(2) A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;

(3) A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;

(4) Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and

(5) Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

(c)(1) The insurers shall pay not less than fifty dollars (\$50.00) for each screening mammogram, which shall include payment for both the professional and technical components.

(2) In case of hospital out-patient screening mammography, and comparable situations, when there is a claim for professional services separate from the claim for technical services, the claim for the professional component will not be less than forty percent (40%) of the total fee.

(d) Furthermore, no insurer shall pay for mammographies performed in an unaccredited facility after January 1, 1990.

History. Acts 1989, No. 292, §§ 2-4, 6; 1995, No. 508, § 2; 2001, No. 1604, § 104.

Publisher's Notes. Acts 1989, No. 292, § 2, is also codified as § 20-15-1002.

For legislative intent of Acts 1989, No. 292, § 1, see § 20-15-1001.

Amendments. The 2001 amendment inserted "accident and" in the introductory language of (b); and made minor stylistic changes.

23-79-141. Children's Preventive Health Care Act.

(a) **TITLE.** This section shall be known and may be cited as the "Children's Preventive Health Care Act".

(b) **DECLARATION OF PURPOSES.** The purpose of this section is to assure that all children eighteen (18) years of age and younger are provided with insurance coverage for preventive health care services during their formative years in order to facilitate early detection and prevention of physical and mental illness, thereby avoiding the risks of the extreme costs associated with many preventable childhood diseases. In addition to improving the health of children, providing insurance coverage for children's preventive health care services enhances the care-giving skills of parents and helps strengthen the family unit. Providing insurance coverage for children's preventive health care will also reduce the disruption to the emotional and financial well-being of families that often accompanies physical and mental illness among children.

(c) **DEFINITIONS.** As used in this section:

(1) "Children's preventive health care services" means physician-delivered or physician-supervised services for eligible dependents from birth through eighteen (18) years of age, with periodic preventive care

visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section; and

(2) "Periodic preventive care visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

(d) APPLICABILITY.

(1) Every accident and health insurer, hospital or medical service corporation, health maintenance organization, fraternal benefit society, and self-insured plan transacting accident and health insurance or providing accident and health coverage in this state that delivers, issues for delivery in this state, or renews, extends, or modifies accident and health policies, contracts, certificates, and plans providing hospital and medical coverage on an expense-incurred, service, or prepaid basis, which contracts provide coverage for a family member of the insured person, shall provide to the contract holder coverage for periodic preventive care visits for covered persons from the moment of birth through eighteen (18) years of age.

(2) This section does not apply to disability income, specified disease, medicare supplement, hospital indemnity, or accident-only policies.

(e) COVERAGE.

(1) Each accident and health insurance policy, contract, certificate, or plan providing benefits for children's preventive health care services on a periodic basis shall include twenty (20) visits at approximately the following age intervals:

- (A) Birth;
- (B) Two (2) weeks;
- (C) Two (2) months;
- (D) Four (4) months;
- (E) Six (6) months;
- (F) Nine (9) months;
- (G) Twelve (12) months;
- (H) Fifteen (15) months;
- (I) Eighteen (18) months;
- (J) Two (2) years;
- (K) Three (3) years;
- (L) Four (4) years;
- (M) Five (5) years;
- (N) Six (6) years;
- (O) Eight (8) years;
- (P) Ten (10) years;
- (Q) Twelve (12) years;
- (R) Fourteen (14) years;
- (S) Sixteen (16) years; and
- (T) Eighteen (18) years.

(2) An accident and health insurance policy, contract, certificate, or plan may provide that children's preventive health care services that

are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single physician during the course of one (1) visit.

(f) **REIMBURSEMENT, COINSURANCE, AND DEDUCTIBLES.**

(1) The benefits that are mandated by this section shall be reimbursed at levels established by the Insurance Commissioner that shall not exceed those established for the same services under the Medicaid program in the State of Arkansas.

(2)(A) Benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy.

(B) All other children's preventive health care services will be subject to copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy.

History. Acts 1989, No. 860, § 1; 1995, No. 685, § 1; 2001, No. 1604, §§ 105, 106, 107.

Publisher's Notes. Acts 1989, No. 860, § 3, provided that the coverages afforded by this act shall be effective January 1, 1990.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (d)(1), (e)(1), and (e)(2); inserted "accident and" in (f)(2); and made minor stylistic changes.

23-79-142. Payment for services of psychological examiners.

Every insurer or hospital and medical service corporation that issues a group accident and health insurance policy, contract, or agreement in this state that provides for mental health coverage shall offer coverage for the payment of services rendered by psychological examiners. The offer shall be made either at the time of application for, or upon the first renewal of such a policy, contract, or agreement after July 15, 1991. If such an offer is accepted, the amount paid for services provided by psychological examiners shall be subject to the same limitations as set forth in the policy for mental health coverage.

History. Acts 1991, No. 624, § 1; 2001, No. 1604, § 108.

substituted "accident and health" for "disability" and made minor stylistic changes.

Amendments. The 2001 amendment

23-79-143. [Repealed.]

Publisher's Notes. This section, concerning choice of pharmacy or pharmacist, was repealed by implication by Acts 1995,

Nos. 505 and 1193. The section was derived from Acts 1991, No. 971, §§ 1-7. For present law, see § 23-99-201 et seq.

23-79-144. Minor children — Certain provisions denying or restricting coverage void.

(a)(1) No contract of individual or group health care coverage sold, delivered, issued for delivery, renewed, or offered for sale in this state by any insurer, health maintenance organization, self-funded group,

multiple-employer welfare arrangement, or hospital or medical services corporation shall, directly or indirectly, restrict or deny health care coverage due to the fact that the minor child does not reside with the noncustodial parent or that the parent-child relationship was established through a paternity action or that the minor child is covered through the state-administered medicaid program or that the minor child is not claimed as a dependent on the noncustodial parent's federal or state income tax return.

(2)(A) Furthermore, no insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation shall, directly or indirectly, restrict or deny benefits to a minor child because the child lives outside of its service area.

(B) Benefits provided outside the service area shall be in accordance with the terms and conditions of the health care plan.

(C) All contract of individual or group health care coverage sold, delivered, issued for delivery, renewed, or offered for sale in this state by any insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation shall provide for the immediate enrollment of the minor child or children.

(b) Any insurance policy provision which would deny or restrict coverage to a minor child under such circumstances shall be void as against public policy.

History. Acts 1991, No. 368, § 3; 1995, No. 1179, § 2.

Acts 1995, No. 1179 § 2, is also codified as § 9-14-503.

Publisher's Notes. Acts 1991, No. 368, § 3, is also codified as § 9-14-503.

23-79-145. [Repealed.]

Publisher's Notes. This section, concerning basic health care insurance for children, was repealed by Acts 1995, No.

685, § 2. The section was derived from Acts 1993, No. 1158, §§ 1-7. For present law, see § 23-79-141.

23-79-146. Subrogation recovery.

(a)(1) Any casualty insurer, accident and health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation that issues, delivers, or renews a contract of accident and health insurance or individual or group accident and health care coverage containing a provision for subrogation for any benefits or services of any kind furnished to an insured, or for payments made or credit extended to or on behalf of any covered person for a physical condition or injury caused by a third party or for which a third party may be liable, shall be entitled to receive subrogation benefits from the third party.

(2) In the event that an insured or covered person recovers from a third party, reasonable cost of collection and attorney's fees thereof

shall be assessed against the insurer and the insured in the proportion each benefits from the recovery.

(b) In the event more than one (1) casualty insurer, accident and health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement, or hospital or medical services corporation having contractual subrogation rights is entitled to the subrogation benefits specified in subsection (a) of this section, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurers and the insured in the proportion each benefits from the recovery.

History. Acts 1993, No. 1182, §§ 1, 2, 6; 1995, No. 1020, § 1; 2001, No. 1604, § 109.

Amendments. The 2001 amendment inserted "accident and" in (a)(1) and (b);

and deleted "or disability" preceding "insurance or individual" in (a)(1).

Cross References. Insurer's right of reimbursement, § 23-89-207.

23-79-147. Prescription medication.

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner of the State Insurance Department;

(2) "Insurance policy" means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state by an insurance company, hospital medical corporation, or health maintenance organization; and

(3) "Medical literature" means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 107 Stat. 591 (1993), 42 U.S.C. § 1395x(t)(2)(B), as amended.

(b) No insurance policy that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

(1) The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:

(A) The American Hospital Formulary Service drug information;

(B) The United States Pharmacopoeia dispensing information; or

(2) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

(c) Coverage of a drug required by subsection (b) of this section includes medically necessary services associated with the administration of the drug, provided that such services are covered by the insurance policy.

(d) Subsection (b) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;

(2) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; or

(3) Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

History. Acts 1995, No. 1231, §§ 1, 2; 1999, No. 466, § 1.

Amendments. The 1999 amendment added (a)(3) and made related changes; deleted former (b)(1)(A) and redesignated the remaining subdivisions accordingly; in present (b)(2), substituted “medical lit-

erature” for “major peer reviewed professional medical journals” and for “a from major peer reviewed professional medical journals”; and deleted former (d)(2) and (3) and redesignated the remaining subdivisions accordingly.

23-79-148. Medical transportation services.

(a)(1) Every insurance policy, other than a policy excluded pursuant to subsection (d) of this section, that provides specific coverage exclusively for medical transportation services, that is sold, delivered, issued for delivery, renewed, or offered for sale in this state by an insurer shall contain a provision providing for direct reimbursement to the provider of covered medical transportation service, if the provider has not received payment for those services from any other source.

(2) The service fee charged shall be in accordance with the American Ambulance Association practice guidelines and shall not be more than the normal charge for the services.

(b) This section shall not apply if the provider for the medical transportation services has entered into a contract for direct payment with the insurer.

(c)(1) For the purpose of this section, “direct reimbursement” means the insurer shall pay the medical transportation service directly, pursuant to a claim filed by the insured, and the medical transportation provider shall not demand payment from the insured until having received payment from the insurer.

(2) Upon receiving payment from the insurer, the medical transportation provider may demand payment from the insured for any unpaid portion of the provider’s fee.

(d) This section shall not apply to any accident and health care policy, whether the policy is in the form of a health maintenance

organization evidence of coverage or health care plan as defined in § 23-76-102(4) and (5), or an accident and health policy governed by §§ 23-85-101 — 23-85-134, 23-85-136, and 23-85-137, or a group and blanket accident and health insurance policy governed by §§ 23-86-101 — 23-86-104, 23-86-106 — 23-86-118, or a medicare supplement policy, or any other form.

History. Acts 1997, No. 1320, § 1; in (d), inserted “accident and,” substituted 2001, No. 1604, § 110.

Amendments. The 2001 amendment, made related changes.

23-79-149. Prescription drug benefits.

(a) As used in this section, “insurance policy” means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state, by an insurance company, hospital medical corporation, or health maintenance organization.

(b) No insurance company, hospital medical corporation, or health maintenance organization issuing insurance policies in this state shall contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits under such insurance policies for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

(c)(1) Each insurance policy shall apply the same coinsurance, copayment, and deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in the insurance policy’s network if the provider meets the contract’s explicit product cost determination.

(2) Nothing in this subsection shall be construed to prohibit the insurance policy from applying different coinsurance, copayment, and deductible factors between and among generic and brand name drugs.

(d) Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy’s network.

(e)(1) For the purpose of this subsection, “maintenance drug” means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period greater than thirty (30) days.

(2) Insurance policies shall not insist or mandate any provider to change an enrollee’s maintenance drug, unless the prescribing provider and enrollee agree to such a change.

(3) Notwithstanding other provisions of law to the contrary, insurance policies that change an enrollee’s maintenance drug without the consent of the provider and enrollee shall be liable to the provider or enrollee, or both, for any damages resulting from the change.

(f) The Insurance Commissioner shall enforce the provisions of this section and shall impose and collect a penalty of one thousand dollars

(\$1,000) for the first violation of this section and a penalty of five thousand dollars (\$5,000) for each subsequent violation of this section. In addition, the commissioner shall have all the powers to enforce this section as are granted to the commissioner elsewhere in the Arkansas Insurance Code.

(g) The commissioner shall have all the powers to enforce this section, including, but not limited to, ensuring that the different coinsurance, copayment, and deductible factors applicable between and among generic and brand name drugs are reasonable, as are granted to the commissioner elsewhere in the Arkansas Insurance Code.

History. Acts 1999, No. 1486, § 2.

originally enacted by Acts 1959, No. 148.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-79-150. Health care plan — Health carrier.

(a)(1)(A) “Health care plan” means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a carrier in this state, including indemnity and managed care plans.

(B) “Health care plan” does not mean a plan that provides coverage only for:

(i) A specified accident or accident-only coverage or long-term care insurance as defined in the Long-Term Care Insurance Act, § 23-97-201 et seq.

(ii) A Medicare supplement policy of insurance, as defined by the Insurance Commissioner by regulation;

(iii) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefit Program;

(iv) Any coverage issued under Chapter 55 of Title 10 of the United States Code, existing on January 1, 2001, and any coverage issued as supplemental to that coverage; and

(v) Any coverage issued as supplemental to liability insurance, workers’ compensation, or similar insurance; and

(2) “Health carrier” means any accident and health insurance company, referred to in law as disability insurance company, hospital or medical services corporation, or health maintenance organization, including a so-called dental maintenance organization, issuing or delivering health care plans in this state.

(b)(1) Every health carrier shall offer optional coverage in its health care plans for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures.

(2) This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

(3) This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.

(c)(1) The policyholder shall accept or reject the optional coverage in writing on the application.

(2) The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

(d) Nothing in this section shall prevent an insurer from including such coverage for any or all musculoskeletal disorders affecting any bone or joint in the face, neck, or head as part of a policy's basic coverage, in lieu of offering optional coverage.

(e) This section shall apply to those health care plans issued, delivered, renewed, extended, amended, or modified on or after August 13, 2001.

History. Acts 2001, No. 1470, §§ 1, 2.

23-79-151. Liability insurance — Notice requirements prior to expiration of policy.

(a)(1) When an insurer writing workers' compensation insurance, employers' liability insurance, or professional liability insurance, including, but not limited to, medical malpractice insurance, revises its rates or rules and the revision results in a premium increase equal to or greater than twenty-five percent (25%) on any renewal policy issued for a term of twelve (12) months or less, the insurer shall mail or deliver to the insured's agent not less than sixty (60) days prior to the effective date of renewal and to the insured not less than thirty (30) days prior to the effective date of renewal notice specifically stating the insurer's intention to increase the premium by an amount equal to or greater than twenty-five percent (25%).

(2) If the notice is not given as stated in subdivision (a)(1) of this section, the insurer is required to extend the existing policy sixty (60) days from the date the notice is mailed or delivered. The premium for the policy as extended in such circumstances shall be no more than the pro rata premium of the existing policy.

(b) Except in the case of nonpayment of premium, an insurer shall renew a policy unless a written notice of nonrenewal is mailed at least sixty (60) days prior to the:

(1) Expiration date of the policy; or

(2) Anniversary date of a policy for a term longer than one (1) year and not having a fixed expiration date.

History. Acts 2003, No. 1790, § 1.

SUBCHAPTER 2 — SUITS AGAINST INSURERS

SECTION.

23-79-201. Claims arising outside the United States — Automobile liability insurer.

SECTION.

23-79-202. Limitation of actions.

23-79-203. Trial by jury.

23-79-204. Venue.

SECTION.

- 23-79-205. Service of process.
- 23-79-206. Evidence of death of person in military service.
- 23-79-207. Substantial compliance — Fire insurance upon personal property.
- 23-79-208. Damages and attorney's fees on loss claims.

SECTION.

- 23-79-209. Allowance of attorney's fees in suits to terminate, modify, or reinstate policy.
- 23-79-210. Direct cause of action against liability insurer when insured not subject to tort suit.

Effective Dates. Acts 1999, No. 135, § 6: Feb. 17, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly that insurers are seeking an award of attorneys' fees as the prevailing party in litigation involving disputes over the coverage of losses under policies of insurance. If successful, this will result in a chilling effect on insurance policyholders' good faith challenge of an insurer's denial of coverage. This is a result never intended by the General Assembly and which will have a negative impact on the policyhold-

ers and economy of this state. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

RESEARCH REFERENCES

Am. Jur. 44A Am. Jur. 2d, Ins., § 1902 et seq.

C.J.S. 46A C.J.S., Ins., § 1520 et seq.

23-79-201. Claims arising outside the United States — Automobile liability insurer.

A person having a claim for personal injury or property damage arising out of the use of a motor vehicle in a foreign country by another who, at the time of the injury or damage, was covered by a policy of automobile liability insurance with an insurer subject to the jurisdiction of the courts of this state, may sue the insurer directly on the claim in any court of competent jurisdiction in the county of which the person was a resident at the time the injury or damage occurred.

History. Acts 1965, No. 130, § 1; A.S.A. 1947, § 66-3244.

RESEARCH REFERENCES

Ark. L. Rev. Leflar, Conflict of Laws: Arkansas, 1978-82, 36 Ark. L. Rev. 191.

23-79-202. Limitation of actions.

(a) An action may be maintained in the courts of this state by an insured or any other person on his or her behalf to recover on any claim or loss arising under a policy of insurance on property or life against the insurer issuing the policy or against the sureties on any bond filed by the insurer as a condition precedent to its right to do business in this state, at any time within the period prescribed by law for bringing actions on promises in writing.

(b) Any stipulation or provision in the policy or contract requiring the action to be brought within any shorter time or be barred is void.

History. Acts 1959, No. 148, § 299; A.S.A. 1947, § 66-3232. tion on instruments in writing, § 16-56-111.

Cross References. Limitation of ac-

CASE NOTES

ANALYSIS

Accrual of cause of action.

Disability clause.

Foreign policy.

Fraternal benefit societies.

Surety insurance.

Accrual of Cause of Action.

Former section did not limit the right of parties to a contract as to when or under what conditions a cause of action on an insurance policy shall arise. *Pacific Mut. Life Ins. Co. v. Butler*, 190 Ark. 282, 78 S.W.2d 813 (1935) (decision under prior law).

Disability Clause.

Former section applied to an action on the disability clauses of a life policy so as to render void a clause attempting to create a limitations period shorter than one prescribed in former section. *Mutual Benefit Health & Accident Ass'n v. Warrell*, 96 F.2d 447 (8th Cir. 1938), cert. denied, 305 U.S. 612, 59 S. Ct. 71, 83 L. Ed. 390 (1938) (decision under prior law).

Foreign Policy.

Former section prevailed as against time limitation fixed in policy issued in

foreign state. *Gulf Ins. Co. v. Holland Constr. Co.*, 218 Ark. 405, 236 S.W.2d 1003 (1951) (decision under prior law).

Fraternal Benefit Societies.

Former section did not apply to policies issued by fraternal benefit societies. *Phillips v. Mosaic Templars of Am.*, 154 Ark. 173, 241 S.W. 869 (1922); *Liebe v. Sovereign Camp, W.O.W.*, 205 Ark. 540, 170 S.W.2d 370 (1943) (preceding decisions under prior law).

Surety Insurance.

Fidelity bond executed by insurers was surety insurance and not property insurance and, therefore, the plaintiff could not invoke the proscription of this section to void a limitation provision shorter than the one prescribed by this section contained in the bond. *Chandler Trailer Co. v. Lawyer's Sur. Corp.*, 535 F. Supp. 204 (E.D. Ark. 1982).

Cited: *First Pyramid Life Ins. Co. of Am. v. Stoltz*, 311 Ark. 313, 843 S.W.2d 842 (1992), cert. denied, 510 U.S. 908, 114 S. Ct. 290, 126 L. Ed. 2d 239 (1993).

23-79-203. Trial by jury.

(a) No insurance policy or annuity contract shall contain any condition, provision, or agreement which directly or indirectly deprives the insured or beneficiary of the right to trial by jury on any question of fact arising under the policy or contract.

(b) All such provisions, conditions, or agreements shall be void.

History. Acts 1959, No. 148, § 300;
A.S.A. 1947, § 66-3233.

CASE NOTES.

ANALYSIS

Valid provisions.

Void provisions.

Valid Provisions.

A clause in an accident policy limiting an insurer's liability for the insured's death from the discharge of a firearm, unless shown to be accidental by testimony of an eyewitness, was not in conflict with former section since the risk could have been accepted altogether. *Interstate Bus. Men's Accident Ass'n v. Adams*, 178 Ark. 856, 13 S.W.2d 591 (1929) (decision under prior law).

Void Provisions.

Policy provisions for arbitration of disputes between insurer and insured concerning liability and/or loss void. *Firemen's Ins. Co. v. Davis*, 130 Ark. 576, 198 S.W. 127 (1917); *Papan v. Resolute Ins. Co.*, 219 Ark. 907, 245 S.W.2d 565 (1952); *Wortman v. Safeco Ins. Co. of Am.*, 227 F. Supp. 468 (E.D. Ark. 1963) (preceding decisions under prior law).

A clause in a policy binding the parties to an appraisal of the damages was void. *Insurance Co. of N. Am. v. Kempner*, 132 Ark. 215, 200 S.W. 986 (1918) (decision under prior law).

Invalidity of arbitration provision did not leave the insured without a remedy but permitted determination of such disputes by litigation. *Wortman v. Safeco Ins. Co. of Am.*, 227 F. Supp. 468 (E.D. Ark. 1963).

A policy provision that no judgment against an alleged uninsured motorist should be conclusive as between the insured and the insurer of the issues of liability or of the amount to which the insured is legally entitled unless such judgment was pursuant to an action prosecuted by the insured with the written consent of the insurer is void. *Robey v. Safeco Ins. Co. of Am.*, 270 F. Supp. 473 (W.D. Ark. 1967), *aff'd*, 399 F.2d 330 (8th Cir. 1968).

An insurance contract executed in Arkansas between an Arkansas resident and a foreign insurance company authorized to do business in Arkansas could not be the subject of arbitration in the home state of the insurer and under the law of that state. *Allstate Ins. Co. v. Harrison*, 307 F. Supp. 743 (W.D. Ark. 1969).

Cited: *MFA Mut. Ins. Co. v. Bradshaw*, 245 Ark. 95, 431 S.W.2d 252 (1968).

23-79-204. Venue.

(a) An action brought in this state by or in behalf of the insured or beneficiary against an insurer as to a loss occurring or benefits or rights provided under an insurance policy or annuity contract shall be brought in either:

(1) The county in which the loss occurred, or the insured died, in the case of life insurance; or

(2) The county of the insured's residence at the time of the loss or death.

(b) Actions brought in this state against an insurer under § 23-79-210, which provides that the liability insurer may be sued directly where the insured is legally immune, shall be brought either in the county where the injury or damage occurred or where one (1) or more of the plaintiffs resided at the time of the injury or damage.

(c) The venue of all other actions against a domestic insurer shall be as provided in § 16-60-104.

History. Acts 1959, No. 148, § 301;
A.S.A. 1947, § 66-3234.

CASE NOTES

ANALYSIS

Actions for losses or benefits.
County of residence or loss.
Foreign defendants.
Subrogation.

Actions for Losses or Benefits.

Holder of accident insurance policy could not sue insurer for overpayment of premiums in county of insured, since plaintiff was not suing for a loss under policy or as beneficiary, hence suit was required to be filed in county where insurer had its principal place of business. *American Republic Life Ins. Co. v. Cummings*, 218 Ark. 888, 239 S.W.2d 10 (1951) (decision under prior law).

Action to reform contract and for damages after reformation of contract held not to be an action for loss or benefits under the policy. *Shelter Mut. Ins. Co. v. Taylor*, 281 Ark. 60, 661 S.W.2d 369 (1983).

County of Residence or Loss.

Suit on bond of insurance company could be brought in any county where loss occurred. *Neimeyer v. Claiborne*, 87 Ark. 72, 112 S.W. 387 (1908) (decision under prior law).

An action by the beneficiary on an insurance policy must be brought in the county where the insured lived or in the county in which he died. *Metropolitan Life Ins. Co. v. Baker*, 197 Ark. 61, 122 S.W.2d 951 (1938) (decision under prior law).

The right to sue on public liability insurance in the county of the residence of the plaintiff or the county where the collision occurred was conferred. *American Fid. & Cas. Co. v. McKee*, 198 Ark. 601, 130 S.W.2d 12 (1939) (decision under prior law).

Although a policy was issued and delivered to the insured in one county and he died in another county, a finding that the insured was a resident of the first county, although absent therefrom at the time of his death, was supported by the testimony and the action on the policy was properly brought in the county of his residence. *National Life & Accident Ins. Co. v. Young*, 200 Ark. 955, 141 S.W.2d 838 (1940) (decision under prior law).

Where insured was certified to state sanatorium from county where he resided, circuit court county where sanatorium was located had jurisdiction of action on health policy, instituted therein, against foreign insurer, absent showing that insured did not intend to change his residence. *Mutual Benefit Health & Accident Ass'n v. Kincannon*, 202 Ark. 1128, 155 S.W.2d 687 (1941) (decision under prior law).

An action on a fire insurance policy may be brought where a mortgagee under a loss payable clause resides, because it is an assured since it will be indemnified. *Seaboard Fire & Marine Ins. Co. v. Keys*, 224 Ark. 648, 275 S.W.2d 640 (1955) (decision under prior law).

The residence of the beneficiary on the surety bond and the county in which the loss occurred are sufficient to establish venue on a subcontractor's complaint against a surety. *Ray Ross Constr. Co. v. Raney*, 266 Ark. 606, 587 S.W.2d 46 (1979).

Venue held proper against surety company in county in which loss occurred; however, venue was not proper against nonresident firm and individual which shared no joint and common liability with the surety company. *Atkins Pickle Co. v. Burrough-Uerling-Brasuell Consulting Eng'rs, Inc.*, 271 Ark. 897, 611 S.W.2d 775 (Ct. App. 1981).

Foreign Defendants.

An action on a fire insurance policy may be brought against a foreign insurance company in a county where the loss occurs, and this provision applies equally to foreign and domestic companies. *Bankers' Fire Ins. Co. v. Williams*, 176 Ark. 1188, 5 S.W.2d 916 (1928) (decision under prior law).

Subrogation.

Section 23-89-101 is a subrogation statute, and the action permitted by it is contractual in nature and not for personal injury; thus, venue is determined not by § 16-60-112 but by § 16-60-116 or this section. *Equity Fire & Cas. Ins. Co. v. Coleman*, 326 Ark. 100, 928 S.W.2d 796 (1996).

Cited: *Coley v. Green*, 232 Ark. 289, 335 S.W.2d 720 (1960); *Universal C.I.T. Credit Corp. v. Troutt*, 235 Ark. 38, 357 S.W.2d 507 (1962); *Farm Bureau Mut. Ins. Co. v. Southall*, 281 Ark. 141, 661 S.W.2d 383 (1983), *aff'd on other grounds*, 283 Ark. 335, 676 S.W.2d 228 (1984); *Mark Twain*

Life Ins. Corp. v. Cory, 283 Ark. 55, 670 S.W.2d 809 (1984); *Allstate Ins. Co. v. Bourland*, 296 Ark. 488, 758 S.W.2d 700 (1988); *Prairie Implement Co. v. Circuit Court*, 311 Ark. 200, 844 S.W.2d 299 (1992).

23-79-205. Service of process.

(a) In any suit brought in this state against an insurer, process may be served upon the insurer as follows:

(1) As to domestic insurers, service of process may be had only in the manner as provided by § 16-58-124;

(2) As to licensed foreign or alien insurers, service on and after January 1, 2003, may be made as provided in § 23-63-301 et seq.;

(3) As to suits against unauthorized insurers, service of process shall be made as provided in §§ 23-65-101 — 23-65-104, 23-65-201 et seq., and 23-65-301 — 23-65-318 for unauthorized insurers and surplus lines.

(b) Any service of process shall be returnable to the court having jurisdiction under § 23-79-204.

History. Acts 1959, No. 148, § 302; A.S.A. 1947, § 66-3235; Acts 2001, No. 1604, § 111.

Amendments. The 2001 amendment, in (a)(2), substituted “licensed foreign or alien” for “foreign,” substituted “on and

after January 1, 2003, may be made” for “may be had upon the commissioner,” and substituted “§ 23-63-301 et seq.” for “§§ 23-63-301 and 23-63-302, 23-63-303 and 23-63-304.”

CASE NOTES

Cited: *Globe Life Ins. Co. v. Humphries*, 258 Ark. 118, 522 S.W.2d 669 (1975).

23-79-206. Evidence of death of person in military service.

(a) It shall be competent and proper in the trial of causes arising from death claims against insurers, accruing on account of death of the insured in foreign lands and while in the service of the United States Government as a member of the armed forces of the United States, to introduce as evidence a certificate from the appropriate officer of the armed services having the authority to make the certificate, certifying the death of the insured.

(b) When the certificate, officially signed and certified as provided in subsection (a) of this section, has been introduced in evidence in the trial, it shall be received and considered in the trial as *prima facie* evidence of the death of the insured.

History. Acts 1959, No. 148, § 303; A.S.A. 1947, § 66-3236.

CASE NOTES

Sufficiency of Evidence.

Introduction of a certificate of the adjutant general of the War Department (now Department of Defense) that an insured person had died in battle while in the military forces of the United States was

sufficient to support a finding that the insured was killed while in the military service of the United States in time of war. *Watkins v. Louisiana State Life Ins. Co.*, 151 Ark. 596, 237 S.W. 89 (1922) (decision under prior law).

23-79-207. Substantial compliance — Fire insurance upon personal property.

In all actions against any insurer for any claim accruing, or arising upon, or growing out of any fire insurance policy upon personal property issued by the insurer, proof of a substantial compliance with the terms, conditions, and warranties of the policy upon the part of the insured or his or her assigns shall be deemed sufficient and entitle the plaintiff to recover in the action.

History. Acts 1959, No. 148, § 304; A.S.A. 1947, § 66-3237.

mation from insurance applicants, § 23-88-201 et seq.

Cross References. Anti-arson infor-

RESEARCH REFERENCES

Ark. L. Rev. Young, Insurance Policy Defenses: In Search of Restatements, 34 Ark. L. Rev. 507.

UALR L.J. Seventeenth Annual Survey of Arkansas Law — Insurance, 17 UALR L.J. 451.

CASE NOTES

ANALYSIS

Compliance required.
Warranties.

Compliance Required.

Former similar section established the rule that a substantial as contradistinguished from a strict compliance with the terms, conditions and warranties in fire insurance policies was sufficient. Security

Mut. Ins. Co. v. Berry, 81 Ark. 92, 98 S.W. 693 (1906) (decision under prior law).

Warranties.

The record warranty in a fire insurance policy is complied with where an inventory was taken within a year and a set of books such as merchants usually keep was kept. *Merchants' Ins. Co. v. Barton*, 182 Ark. 725, 32 S.W.2d 1069 (1930) (decision under prior law).

23-79-208. Damages and attorney's fees on loss claims.

(a)(1) In all cases in which loss occurs and the cargo, property, marine, casualty, fidelity, surety, cyclone, tornado, life, accident and health, medical, hospital, or surgical benefit insurance company and fraternal benefit society or farmers' mutual aid association or company liable therefor shall fail to pay the losses within the time specified in the policy after demand is made, the person, firm, corporation, or association shall be liable to pay the holder of the policy or his or her assigns, in addition to the amount of the loss, twelve percent (12%) damages upon the amount of the loss, together with all reasonable attorney's fees for the prosecution and collection of the loss.

(2) In no event will the holder of the policy or his or her assigns be liable for the attorney's fees incurred by the insurance company, fraternal benefit society, or farmers' mutual aid association in the defense of a case in which the insurer is found not liable for the loss.

(b) When attorney's fees are due a policyholder or his or her assigns, they shall be taxed by the court where the same is heard on original action, by appeal or otherwise, and shall be taxed up as a part of the costs therein and collected as other costs are or may be by law collected.

(c) Writs of attachment or garnishment filed or issued after proof of loss or death has been received by the company shall not defeat the provisions of this section, provided that the company or association desiring to pay the amount of the claim as shown in the proof of loss or death may pay the amount into the registry of the court, after issuance of writs of attachment and garnishment, in which event there shall be no further liability on the part of the company.

(d) Recovery of less than the amount demanded by the person entitled to recover under the policy shall not defeat the right to the twelve percent (12%) damages and attorney's fees provided for in this section if the amount recovered for the loss is within twenty percent (20%) of the amount demanded or which is sought in the suit.

(e)(1) Notwithstanding the foregoing provisions of subsections (a)-(d) of this section, this section is not intended to either vitiate or supplant the provisions of the Arkansas Rules of Civil Procedure. Those rules and the relief described therein remain available to any litigant under the circumstances described in this section.

(2) Nothing in this section is intended to supersede, supplant, or in any way affect the rights and remedies under applicable law currently available to the insurance company, fraternal benefit society, or farmers' mutual aid association or company against policyholders who file fraudulent claims.

History. Acts 1959, No. 148, § 305; 1965, No. 437, § 1; A.S.A. 1947, § 66-3238; Acts 1991, No. 349, § 1; 1999, No. 135, § 1; 2001, No. 1604, §§ 112, 113.

Publisher's Notes. Acts 1999, No. 135, § 2, provided: "It is the express intent of the General Assembly that this Act be applied retroactively to pending cases, as it is remedial and procedural in nature."

Acts 1999, No. 135, § 5, provided: "All laws and parts of laws in conflict with this Act are hereby repealed. Specifically, any other law or parts of law of general application regarding the award of attorneys' fees, as applied in litigation involving policies of insurance, are superseded by the provisions of this Act. Specifically, the

provisions of § 16-22-308 regarding the award of attorneys' fees to the prevailing party in a civil action for breach of contract are expressly superseded by the provisions of this Act."

Amendments. The 1999 amendment added (a)(2); substituted "When attorney's fees are due a policyholder or his assigns, they" for "The attorney's fee" in (b); and added (e).

The 2001 amendment, in (a)(1), substituted "property" for "fire," substituted "accident and health, medical" for "health, accident, medical," substituted "is made" for "made therefor," and inserted "or her"; and inserted "or company" in (a)(1) and (e)(2).

RESEARCH REFERENCES

Ark. L. Notes. Brill, A Primer on Judgment and Pre-Judgment Interest in Arkansas, 1989 Ark. L. Notes 1.

Copeland, A Brief Survey of Some Important 1990 Insurance Law Decisions, 1991 Ark. L. Notes 75.

Copeland, A Brief Survey of Some Important 1991 and 1992 Insurance Law Decisions, 1992 Ark. L. Notes 85.

Ark. L. Rev. Holmes, Third Party Insurance Excess Liability and Its Avoidance, 34 Ark. L. Rev. 525.

Notes, *Aetna v. Broadway Arms: The Tort of Bad Faith*, 38 Ark. L. Rev. 462.

UALR L.J. Bassett, Survey of Arkansas Law: Insurance, 2 UALR L.J. 247.

Arkansas Law Survey, Stewart, Insurance, 8 UALR L.J. 183.

Casey, Bad Faith in First Party Insurance Contracts — What's Next?, 8 UALR L.J. 237.

Survey, Insurance, 14 UALR L.J. 379.

Seventeenth Annual Survey of Arkansas Law — Insurance, 17 UALR L.J. 451.

CASE NOTES

ANALYSIS

Constitutionality.

Construction.

Purpose.

Applicability.

Amount.

—Attorney's fees.

—Damages.

Confession of judgment.

Costs.

Counterclaims.

Declaratory judgment.

Defense or justification.

Demand.

Excess liability carriers.

Insurer's liability.

Insurer's rights.

Interest.

Jurisdiction.

Liability.

Loss-payees.

Parties protected.

Receivership.

Recovery on principal claim.

—Reduction of claim.

—Untimely payment of claim.

State's authority.

Tort actions.

Constitutionality.

Former section did not violate due process or equal protection clause even though construed as imposing liability where refusal is in good faith and on reasonable grounds. *Missouri State Life Ins. Co. v. Fodrea*, 185 Ark. 155, 46 S.W.2d 638 (1932); *Life & Cas. Ins. Co. v. McCray*, 291 U.S. 566, 54 S. Ct. 482, 78 L. Ed. 987 (1934); *Missouri State Life Ins. Co. v. Brown*, 188 Ark. 1136, 69 S.W.2d 1075 (1934) (decision under prior law).

Construction.

Former section was highly penal and should be strictly construed. *National Fire Ins. Co. v. Kight*, 185 Ark. 386, 47 S.W.2d 576 (1932); *LaSalle Fire Ins. Co. v. Jenkins*, 185 Ark. 484, 47 S.W.2d 792 (1932); *Sun Life Assurance Co. v. Coker*, 187 Ark. 602, 61 S.W.2d 447 (1933); *National Old Line Ins. Co. v. Russell*, 188 Ark. 632, 67 S.W.2d 195 (1934); *Taylor v. Mutual Life Ins. Co.*, 193 Ark. 251, 98 S.W.2d 944 (1936); *Broadaway v. Home Ins. Co.*, 203 Ark. 126, 155 S.W.2d 889 (1941); *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955); *Tollett v. Phoenix Assurance Co.*, 147 F. Supp. 597 (W.D. Ark. 1956) (preceding decisions under prior law).

For cases decided prior to the 1991 amendment holding that, since this section was penal in nature, it must be strictly construed; and/or the plaintiff must recover the exact amount claimed, in order to collect the penalty and attorneys' fees, see *Miller's Mut. Ins. Co. v. Keith Smith Co.*, 284 Ark. 124, 680 S.W.2d 102 (1984); *Cato v. Arkansas Mun. League Mun. Health Benefit Fund*, 285 Ark. 419, 688 S.W.2d 720 (1985); *Stuckey v. Time Ins. Co.*, 669 F. Supp. 261 (E.D. Ark. 1987), aff'd, 860 F.2d 1084 (8th Cir. 1988) *Credit Gen. Ins. Co. v. Atlas Asphalt, Inc.*, 304 Ark. 522, 803 S.W.2d 903 (1991).

The Arkansas Supreme Court has construed this section to allow insurers to conduct a reasonable and timely investigation, and the district court did not err in concluding that the exception continues to apply even when the mandatory two-month period of § 23-81-113(b) governs

the payment of the insurance claim. *McKee v. Federal Kemper Life Assurance Co.*, 927 F.2d 326 (8th Cir. 1991).

This section, being penal in nature, is strictly construed. *State Farm Mut. Auto. Ins. Co. v. Thomas*, 316 Ark. 345, 871 S.W.2d 571 (1994).

Subsection (d) of this section, being penal in nature, is strictly construed. *National Std. Ins. Co. v. Westbrooks*, 331 Ark. 445, 962 S.W.2d 355 (1998).

Purpose.

Former section was not intended to penalize an insurer for policies written and matured in another state. *Business Men's Accident Ass'n v. Cowden*, 131 Ark. 419, 199 S.W. 108 (1917); *Inter-Ocean Cas. Co. v. Warfield*, 173 Ark. 287, 292 S.W. 129 (1927); *New York Life Ins. Co. v. Miller*, 139 F.2d 657 (8th Cir. 1944) (preceding decisions under prior law).

Former section was part of a contract of insurance and was to reimburse the plaintiff for expenses incurred in enforcing the contract. *Sun Life Assurance Co. v. Coker*, 187 Ark. 602, 61 S.W.2d 447 (1933) (decision under prior law).

Recoveries for penalty and fees were intended to prevent defenses for delay or other vexatious litigation, and as a restraint against unreasonable contentions of the insured, for he may not recover these items unless he recovers first the amount sought by suit (now within 20% of amount demanded or sought in the suit). *John Hancock Mut. Life Ins. Co. v. Magers*, 199 Ark. 104, 132 S.W.2d 841 (1939) (decision under prior law).

The General Assembly did not intend to impose a penalty on an insurer for exercising its right to timely seek a new trial or timely obtain appellate review, but instead, the penalty nature of this section is directed against unwarranted delaying tactics of insurers. *Simmons First Nat'l Bank v. Liberty Mut. Ins. Co.*, 282 Ark. 194, 667 S.W.2d 648 (1984).

The penalty nature of this section is directed against unwarranted delaying tactics of insurers. *State Farm Mut. Auto. Ins. Co. v. Thomas*, 316 Ark. 345, 871 S.W.2d 571 (1994).

Applicability.

Former section was applicable to a suit brought by an insurance company to cancel insured's policy, where defendant by

counterclaim recovered for disability from insanity. *Old Colony Life Ins. Co. v. Julian*, 175 Ark. 359, 299 S.W. 366 (1927) (decision under prior law).

Former section applied to stipulated premium companies. *Old Am. Ins. Co. v. Hartsell*, 176 Ark. 666, 4 S.W.2d 25 (1928) (decision under prior law).

Former section was inapplicable to liability insurance companies. *Standard Accident Ins. Co. v. Philpot Constr. Co.*, 183 Ark. 694, 38 S.W.2d 26 (1931) (decision under prior law).

An insurance company insuring automobiles against loss by fire was a fire insurance company. *LaSalle Fire Ins. Co. v. Jenkins*, 185 Ark. 484, 47 S.W.2d 792 (1932) (decision under prior law).

The statutory penalty against an insurer was applicable to the breach of a policy providing for a weekly benefit in case of permanent disability from sickness. *National Life & Accident Ins. Co. v. Sims*, 187 Ark. 969, 63 S.W.2d 524 (1933) (decision under prior law).

Where a certificate under a group policy was delivered to the insured in Arkansas and it was not effective until delivered, former section applied although the insurer and the holder of the group policy were nonresidents. *Metropolitan Life Ins. Co. v. Harper*, 189 Ark. 170, 70 S.W.2d 1042 (1934) (decision under prior law).

Where the parties of a life policy were both foreign and from different states and the policy was payable in insurer's home state and was delivered and matured in insured's home state, former section was not applicable. *New York Life Ins. Co. v. Miller*, 139 F.2d 657 (8th Cir. 1944) (decision under prior law).

If any insurance came within a type of insurance specified by the statute as such type was defined by the insurance law, such insurance was covered by the provisions of former statute. *Liverpool & London & Globe Ins. Co. v. Jones*, 207 Ark. 237, 180 S.W.2d 519 (1944) (decision under prior law).

This section applies to an action on a bond executed under a United States statute where the statute under which it is executed is silent on the question of interest, penalty, and attorney's fees. *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955); *Lewis v. Goldsborough*, 234 F.

Supp. 524 (E.D. Ark. 1964) (decision under prior law).

Notwithstanding that insurance policy is a foreign contract, if it matures in Arkansas and action thereon is brought in Arkansas, the Arkansas statute providing for attorney's fees and penalties applies. *Aetna Cas. & Sur. Co. v. Simpson*, 228 Ark. 157, 306 S.W.2d 117 (1957); *State Farm Mut. Auto. Ins. Co. v. Fuller*, 232 Ark. 329, 336 S.W.2d 60 (1960) (preceding decisions under prior law).

Former section applied to mutual aid associations. *Farmers Union Mut. Ins. Co. v. Myers*, 234 Ark. 1061, 356 S.W.2d 423 (1962) (decision under prior law).

The factoring agreement between the parties was not an insurance contract but a contract for the purpose of purchasing accounts receivable, thus appellees were not entitled to the penalty and attorney's fee required by this section. *Manhattan Factoring Corp. v. Orsburn*, 238 Ark. 947, 385 S.W.2d 785 (1965).

The provisions of this section do not extend to declaratory judgment proceedings. *Mid-South Ins. Co. v. Dellinger*, 239 Ark. 169, 388 S.W.2d 6 (1965).

This section will apply in an action on an accident insurance policy when the insured was living in this state when the policy was issued. *New Empire Life Ins. Co. v. Bowling*, 241 Ark. 1051, 411 S.W.2d 863 (1967).

Workmen's compensation insurance covering employees which do not come within the Arkansas Workmen's Compensation Law is a form of casualty insurance and as such is included in this section. *Empire Life & Hosp. Ins. Co. v. Armored Planting Co.*, 247 Ark. 994, 449 S.W.2d 200 (1970).

Statutory penalty and attorney's fee have been allowed only in cases having a connection with this state, and are not allowed on an uninsured motorist policy maturing outside of Arkansas and issued in another state to a nonresident. *Allstate Ins. Co. v. Ormand*, 252 Ark. 773, 480 S.W.2d 939 (1972).

This section applied to cases in which the insured recovered money judgment and was not pertinent where a principal merely prevailed in an action by his surety to recover amount of claim paid by surety. *Fireman's Fund Ins. Co. v. Clark*, 253 Ark. 1025, 490 S.W.2d 447 (1973).

This section has been applied to sure-

ties on contractor's bonds, where the sureties contended the proper demand to justify allowance of penalty and attorneys' fees had not been made. *Ray Ross Constr. Co. v. Raney*, 266 Ark. 606, 587 S.W.2d 46 (1979); *R.J. "Bob" Jones Excavating Contractor v. Firemen's Ins. Co.*, 324 Ark. 282, 920 S.W.2d 483 (1996).

This section applies regardless of whether the late payment is made to the insured or insured's mortgagee. *Farm Bureau Mut. Ins. Co. v. Shaw*, 269 Ark. 757, 600 S.W.2d 432 (Ct. App. 1980).

This section did not apply where the contract between employer and insurer was a contract to provide insurance coverage to employees, not to the employer; the employees were the policy holders of whatever policies existed under this agreement, and, moreover, the basis of employer's lawsuit was breach of contract because insurer overcharged employer for insurance claims paid by insurer. *P.A.M. Transp., Inc. v. Arkansas Blue Cross & Blue Shield*, 315 Ark. 234, 868 S.W.2d 33 (1993), *supp. op.*, 315 Ark. 250-A, — S.W.2d — (1994).

In former employee's action against her employer's insurance company for breach of contract in failing to pay disability benefits, the employee's claim for assessment of a 12 percent penalty pursuant to this section was preempted by ERISA. *Burkett v. Sun Life Assurance Co. of Can.*, 958 F. Supp. 432 (E.D. Ark. 1997).

Amount.

The allowance of the statutory penalty and attorney's fees is penal in nature and is a procedural matter governed by the laws of the State of Arkansas. *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988).

Attorney's fees, 12% penalty, and interest awarded to materialman who recovered a verdict against surety on a contractor's bond. *General Elec. Supply Co. v. Downtown Church of Christ*, 24 Ark. App. 1, 746 S.W.2d 386 (1988).

Attorney's fee award of over \$10,000 on a claim valued at \$1,646 upheld. *Parker v. Southern Farm Bureau Cas. Ins. Co.*, 326 Ark. 1073, 935 S.W.2d 556 (1996).

—Attorney's Fees.

The allowance for attorney's fee must be reasonable. *Merchants' Fire Ins. Co. v. McAdams*, 88 Ark. 550, 115 S.W. 175

(1908); *Colorado Life Co. v. Steele*, 95 F.2d 535 (8th Cir. 1938) (preceding decisions under prior law); *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974).

Former section contemplated the employment of only one competent attorney and it was error to allow fees to two different attorneys. *Mutual Life Ins. Co. v. Owen*, 111 Ark. 554, 164 S.W. 720 (1914); *Aetna Life Ins. Co. v. Heiden*, 184 Ark. 291, 42 S.W.2d 392 (1931); *Franklin Life Ins. Co. v. Burgess*, 219 Ark. 834, 245 S.W.2d 210 (1952) (preceding decisions under prior law).

Attorney's fee held reasonable. *Commercial Cas. Ins. Co. v. McCulley*, 185 Ark. 468, 48 S.W.2d 225 (1932); *Missouri State Life Ins. Co. v. Barron*, 186 Ark. 46, 52 S.W.2d 733 (1932); *Coal Operators Cas. Co. v. F.S. Neely Co.*, 219 Ark. 579, 243 S.W.2d 744 (1951); *Universal Life & Accident Ins. Co. v. Stuart*, 219 Ark. 863, 245 S.W.2d 219 (1952); *New York Life Ins. Co. v. Thweatt*, 221 Ark. 478, 254 S.W.2d 68 (1953); *Union Life Ins. Co. v. Epperson*, 221 Ark. 522, 254 S.W.2d 311 (1953); *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955); *Equitable Life Assurance Soc'y v. Gordy*, 228 Ark. 643, 309 S.W.2d 330 (1958); *Great Am. Indem. Co. v. State ex rel. Ark. Bitumuls Co.*, 231 Ark. 181, 328 S.W.2d 504 (1959) (preceding decisions under prior law); *Haskins v. Occidental Life Ins. Co.*, 349 F. Supp. 1192 (E.D. Ark. 1972); *Blevins v. Commercial Std. Ins. Cos.*, 544 F.2d 967 (8th Cir. 1976); *New Hampshire Ins. Co. v. Quilantan*, 269 Ark. 359, 601 S.W.2d 836 (1980); *Southall v. Farm Bureau Mut. Ins. Co.*, 283 Ark. 335, 676 S.W.2d 228 (1984); *Shepherd v. State Auto Property & Cas. Ins. Co.*, 312 Ark. 502, 850 S.W.2d 324 (1993).

Reasonable attorneys' fees means such a fee as would be reasonable for a litigant to pay his attorney for prosecuting the case, and not a speculative or contingent fee based upon the uncertainty of the result of the litigation. *Metropolitan Life Ins. Co. v. Leach*, 198 Ark. 531, 129 S.W.2d 588 (1939) (decision under prior law).

A reasonable fee is to be determined by the particular circumstances that appear, it should not only be commensurate with time and amount of work required but also with the ability present and necessary to take care of or meet the issues that

arise, it should not be so low, that well prepared attorneys would avoid that case of litigation, but should be for the purpose of compensating the insured in engaging counsel thoroughly competent to protect his interest. *John Hancock Mut. Life Ins. Co. v. Magers*, 199 Ark. 104, 132 S.W.2d 841 (1939) (decision under prior law).

Attorney's fee allowed held excessive. *Metropolitan Life Ins. Co. v. Leach*, 198 Ark. 531, 129 S.W.2d 588 (1939); *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974) (decision under prior law).

Fees earned in successfully defending a counterclaim for an implied breach of warranty were not includible, since the purpose of former section was only to reimburse the expenses incurred in enforcing the contract. *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955) (decision under prior law).

Additional fee may be taxed on appeals. *Farm Bureau Mut. Ins. Co. v. Cusick*, 235 Ark. 27, 356 S.W.2d 740 (1962); *Southern Farm Bureau Cas. Ins. Co. v. Gooding*, 263 Ark. 435, 565 S.W.2d 421 (1978); *Stafford v. Southern Farm Bureau Cas. Ins. Co.*, 457 F.2d 366 (8th Cir. 1972).

Attorney fees are allowed only to reimburse an insurance policy holder or beneficiary for expenses incurred in enforcing the contract and to compensate in engaging counsel thoroughly competent to protect his interest. *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974).

There is no fixed formula or policy to be considered in arriving at attorney fees other than the rule that the appropriately broad discretion of the trial court in such matters must not be abused. *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974).

An allowance for an attorney fee should not be speculative or contingent but should be such a fee as would be reasonable for a litigant to pay his attorney for prosecuting such a case, however, the amount which the beneficiary receives is an element to be considered along with the difficulty of the issues. *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974).

An allowance of attorney fees must be affirmed unless it is demonstrated, or the record shows, that the allowance is exces-

sive. *Equitable Life Assurance Soc'y v. Rummell*, 257 Ark. 90, 514 S.W.2d 224 (1974).

Attorney's fees awarded would not be reversed absent a showing by the other party that the allowance was excessive, inadequate or unreasonable. *Farm Bureau Mut. Ins. Co. v. Kizziar*, 1 Ark. App. 84, 613 S.W.2d 401 (1981).

The computation of allowable attorney's fees is governed by factors which include the experience and ability of the attorney, the time and work required of him, the amount involved in the case, the results obtained, the fee customarily charged in the locality for similar legal services, and whether the fee is fixed or contingent; while courts should be guided by these factors, there is no fixed formula to be used in determining the reasonableness of a fee. *Southall v. Farm Bureau Mut. Ins. Co.*, 283 Ark. 335, 676 S.W.2d 228 (1984); *Miller's Mut. Ins. Co. v. Keith Smith Co.*, 284 Ark. 124, 680 S.W.2d 102 (1984); *State Farm Fire & Cas. Co. v. Stockton*, 295 Ark. 560, 750 S.W.2d 945 (1988); *Northwestern Nat'l Life Ins. Co. v. Heslip*, 309 Ark. 319, 832 S.W.2d 463 (1992).

In awarding a reasonable attorney's fee, the court's duty is to fix a fee that is reasonable; automatic acceptance of a lawyer's contract with a client would be an abdication of court's duty to supervise the conduct of the bar and do justice to the losing, as well as the winning, side. *Southall v. Farm Bureau Mut. Ins. Co.*, 283 Ark. 335, 676 S.W.2d 228 (1984); *State Farm Fire & Cas. Co. v. Stockton*, 295 Ark. 560, 750 S.W.2d 945 (1988).

The award of an attorney's fee is a matter for the sound discretion of the trial court and in the absence of abuse, its judgment will be sustained on appeal. *Southall v. Farm Bureau Mut. Ins. Co.*, 283 Ark. 335, 676 S.W.2d 228 (1984); *Arkansas Blue Cross & Blue Shield v. Remagen*, 25 Ark. App. 96, 752 S.W.2d 284 (1988).

Attorney's fees are awarded under this section, not as property of the attorney, but by way of indemnity to the litigant. *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*, 22 Ark. App. 89, 733 S.W.2d 429 (1987).

Plaintiff who was litigant, advocate, and witness was entitled to attorney's fees. *Arkansas Blue Cross & Blue Shield,*

Inc. v. Doe, 22 Ark. App. 89, 733 S.W.2d 429 (1987).

Trust specifically afforded an exemption from the provisions of the Insurance Code pursuant to § 23-61-502(3) was not subject to the imposition of the statutory penalty and attorney's fees provided in subsection (a). *Arkansas Poultry Fed'n Ins. Trust v. Lawrence*, 34 Ark. App. 45, 805 S.W.2d 653 (1991).

The standard of review with regard to the reasonableness of attorney's fees awarded by the trial court is one of abuse of discretion, and the trial court is to consider a number of factors in addition to the number of hours worked. *Northwestern Nat'l Life Ins. Co. v. Heslip*, 309 Ark. 319, 832 S.W.2d 463 (1992).

In the amendment to this section by Acts 1991, No. 349, the legislature plainly stated that, to recover the twelve-percent penalty and attorneys' fees, an insured must recover within twenty percent of the amount he demands or seeks in the suit. *National Std. Ins. Co. v. Westbrook*, 331 Ark. 445, 962 S.W.2d 355 (1998).

The factors for determining the amount of attorneys' fees and costs to be awarded on an appeal are the same as the factors for determining the amount of attorneys' fees and costs to be awarded after a trial. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 341 Ark. 452, 17 S.W.3d 83 (2000).

The court properly set the plaintiff's attorney's fee at one-third of the judgment and penalty awarded to the plaintiff, notwithstanding the assertion that the number of hours worked required a larger fee, since the attorney took the case on a contingency fee, the attorney did not have accurate records of his time, and a fee award should not exceed the amount that the client is responsible for paying. *Phelps v. United States Credit Life Ins. Co.*, 340 Ark. 439, 10 S.W.3d 854 (2000).

The district court did not abuse its discretion in awarding \$ 125,000 in attorneys' fees to the plaintiffs where the court considered one affidavit which set forth the plaintiff's contingent fee agreement whereby the expected fee would be one-third of the \$ 500,000 policy limits, or \$ 166,667, and another affidavit which set forth an effective hourly rate of \$ 350 for plaintiff's cases and estimated the amount of time spent on the matter at 250-300 hours, plus 90-100 hours by an associate attorney, plus an additional 20

hours by a paralegal. *Fuller v. Hartford Life Ins. Co.*, 281 F.3d 704 (8th Cir. 2002).

—Damages.

Assessment of penalty in excess of statutory amount was erroneous. *Providence Washington Ins. Co. v. McKenzie*, 221 Ark. 235, 252 S.W.2d 627 (1952) (decision under prior law).

Confession of Judgment.

Where an insurance company offers to confess judgment for the sum named in the face of the policy less the amount of any premium due thereon, neither the insured nor his assignee can recover the penalty and attorney's fee. *Fulmer v. East Ark. Abstract & Loan Co.*, 173 Ark. 668, 293 S.W. 1018 (1927) (decision under prior law).

Attorneys' fees and penalty attach if insured is compelled to file suit even though the judgment may be confessed before trial. *Commercial Union Assurance Co. v. Leftwich*, 191 Ark. 656, 87 S.W.2d 55 (1935); *Equitable Life Assurance Soc'y v. Gordy*, 228 Ark. 643, 309 S.W.2d 330 (1958); *Continental Cas. Co. v. Vardaman*, 232 Ark. 773, 340 S.W.2d 277 (1960) (preceding decisions under prior law); *Federal Life & Cas. Co. v. Weyer*, 239 Ark. 663, 391 S.W.2d 22 (1965); *Farm Bureau Mut. Ins. Co. v. David*, 324 Ark. 387, 921 S.W.2d 930 (1996).

Insured cannot file suit for amount less than theretofore demanded and collect the statutory penalty and attorney's fee if the insurance company timely offers to confess judgment and tenders into court the amount sued for, plus interests and costs to date of tender. *Broadaway v. Home Ins. Co.*, 203 Ark. 126, 155 S.W.2d 889 (1941) (decision under prior law).

Where, after all the evidence was in, appellant offered to confess judgment for the full face value of the policies, there was no error in court's action in directing jury to return verdict for plaintiff and then adding statutory penalty and attorney's fee. *Farm Bureau Mut. Ins. Co. v. Cusick*, 235 Ark. 27, 356 S.W.2d 740 (1962).

Where the insurer previously refused to pay the correct amount claimed, the penalty and attorneys' fees were correctly assessed, even though the insurer later confessed judgment. *Miller's Mut. Ins. Co. v. Keith Smith Co.*, 284 Ark. 124, 680 S.W.2d 102 (1984).

Where an insurance company confessed judgment in the correct amount before the claimant filed an amended complaint asking for the correct amount, the statutory penalty and attorney's fees did not attach. *Garrett v. American Fid. Assurance Co.*, 305 Ark. 74, 805 S.W.2d 78 (1991).

Costs.

The attorney's fee is given as a penalty to reimburse the policyholder for expenses incurred in enforcing the contract of indebtedness and is taxed as costs in the case and therefore is a part of the recovery against the insurance company. *Vaughan v. Humphreys*, 153 Ark. 140, 239 S.W. 730 (1922) (decision under prior law).

Provision in policy providing that any judgment creditor of insured can recover to the extent of the insurance afforded by the policy, does not constitute a limitation as to penalty and attorney fees, since penalty and attorney fees under the act are classed as part of the costs. *Traders & Gen. Ins. Co. v. Powell*, 177 F.2d 660 (8th Cir. 1949) (decision under prior law).

Objections to the trial court's award of costs must be raised in the trial court by a motion to amend the judgment pursuant to ARCP 52(b). *Farm Bureau Mut. Ins. Co. v. David*, 324 Ark. 387, 921 S.W.2d 930 (1996).

Counterclaims.

Nothing in § 23-79-209 would prevent the allowance of the 12% penalty upon a counterclaim for a loss. *Home Ins. Co. v. Crawford*, 251 Ark. 843, 475 S.W.2d 889 (1972).

Declaratory Judgment.

In a declaratory judgment action, the awarding of attorney's fees is proper under § 23-79-209, which does not provide for the 12% penalty set forth in this section. *Silverball Amusement, Inc. v. Utah Home Fire Ins. Co.*, 842 F. Supp. 1151 (W.D. Ark.), *aff'd*, 33 F.3d 1476 (8th Cir. 1994).

This section, rather than § 23-79-209, applied to an action commenced by an insurance company seeking a declaratory judgment that it owed nothing under a motor vehicle policy, where the defendant financial institution (which had loaned money to the insured to purchase the vehicle) filed a counterclaim seeking the policy proceeds and was successful on that counterclaim. *Newcourt Fin., Inc. v. Canal*

Ins. Co., 67 Ark. App. 347, 1 S.W.3d 452 (1999).

Defense or Justification.

Former section did not apply where the company was prevented from making payment by writs of garnishment sued out by plaintiff's creditors. *North State Fire Ins. Co. v. Dillard*, 88 Ark. 473, 115 S.W. 154 (1908) (decision under prior law).

Former section did not make the liability of the company depend upon its good faith in contesting the matter. *American Liberty Mut. Ins. Co. v. Washington*, 183 Ark. 497, 36 S.W.2d 963 (1931); *Life & Cas. Ins. Co. v. McCray*, 187 Ark. 49, 58 S.W.2d 199 (1933), rehearing denied, 292 U.S. 600, 54 S. Ct. 627, 78 L. Ed. 1464 (1934), aff'd, 291 U.S. 566, 54 S. Ct. 482, 78 L. Ed. 987 (1934); *Life & Cas. Ins. Co. v. Barefield*, 187 Ark. 676, 61 S.W.2d 698 (1933), aff'd, 291 U.S. 575, 54 S. Ct. 486, 78 L. Ed. 999, rehearing denied, 292 U.S. 600, 54 S. Ct. 627, 78 L. Ed. 1464 (1934); *Missouri State Life Ins. Co. v. Martin*, 188 Ark. 907, 69 S.W.2d 1081 (1934) (preceding decisions under prior law).

Where a disability claim under a policy covering disability and death benefits had arisen before the insured's death and was in dispute and the insurer admitted liability for the death but refused to pay unless the policy was surrendered as provided in the policy, the insurer was liable for the statutory penalty and attorney's fee although the insured refused to surrender the policy until the claim for disability benefits was settled and had offered to receive the death benefits and execute an acquittance therefor. *Equitable Life Assurance Soc'y v. Felton*, 189 Ark. 327, 72 S.W.2d 225 (1934) (decision under prior law).

Good faith of insurer is not a valid defense. *Life & Cas. Ins. Co. v. Wiggins*, 224 Ark. 377, 273 S.W.2d 405 (1954); *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955); *Willis-Reed Lumber Co. v. New York Underwriters Ins. Co.*, 146 F. Supp. 74 (W.D. Ark. 1956); *Tollett v. Phoenix Assurance Co.*, 147 F. Supp. 597 (W.D. Ark. 1956) (preceding decisions under prior law). But see, *Missouri State Life Ins. Co. v. King*, 186 Ark. 983, 57 S.W.2d 400 (1933); *Taylor v. Mutual Life Ins. Co.*, 193 Ark. 251, 98 S.W.2d 944 (1936) (preceding decisions under prior law).

Filing and prosecuting action by insurer against insured for claims it alleges insured owes constituted no justification for withholding payment on the policies and they are liable for the statutory penalty and attorney's fee. *American Equitable Assurance Co. v. Showers*, 195 Ark. 521, 113 S.W.2d 91 (1938) (decision under prior law).

Where due to statute of limitations insurer was not liable for amount sought by insured in original complaint, but only for amount sought in amended complaint, did not excuse insurer from duty to pay penalty and attorney's fee under this section. *Equitable Life Assurance Soc'y v. Gordy*, 228 Ark. 643, 309 S.W.2d 330 (1958) (decision under prior law).

Where the reason for the delay in payment was the inability of the insurer to come to terms with the mortgagee as to the insurer's rights in the mortgaged property upon payment to mortgagee there was no justification for the delay in payment. *Farm Bureau Mut. Ins. Co. v. Shaw*, 269 Ark. 757, 600 S.W.2d 432 (Ct. App. 1980).

Insurer who had all the pertinent information within a few days of receipt of the proof of loss, and who received the sworn statement of claimant within the sixty-day period stipulated in the contract, could not successfully argue that delay by the claimant should prevent the assessment of penalties under this section. *Farm Bureau Mut. Ins. Co. v. David*, 324 Ark. 387, 921 S.W.2d 930 (1996).

Trial court's decision to award an attorney's fee and court costs and impose a penalty and interest was clearly erroneous where the insurer did not deny the insured's claim but rather requested verification and, once provided with the information, promptly paid benefits. *American Underwriters Ins. Co. v. Turner*, 57 Ark. App. 169, 944 S.W.2d 129 (1997).

Demand.

Finding that a demand for payment was made before suit and that there was a refusal to make payment was warranted and the court was justified in assessing a penalty and attorney's fees. *Metropolitan Life Ins. Co. v. Shane*, 98 Ark. 132, 135 S.W. 836 (1911) (decision under prior law).

Former section did not require a demand other than the filing of suit, and allowance of statutory penalty and attor-

ney's fee was proper in action by subcontractor against surety of public contractor even though there had been no previous demand. *Trinity Universal Ins. Co. v. Smithwick*, 222 F.2d 16 (8th Cir. 1955), cert. denied, 350 U.S. 837, 76 S. Ct. 74, 100 L. Ed. 747 (1955) (decision under prior law).

Filing of counterclaim by prime contractor and its subsidiaries against subcontractor and its surety for damages allegedly caused by subcontractor's refusal to complete subcontract operated as a demand upon surety, making surety liable for statutory penalty and attorney's fees. *Reid v. Miles Constr. Corp.*, 307 F.2d 214 (8th Cir. 1962) (decision under prior law).

Where demand is made and liability under the contract is established attorneys' fees and penalty attached in absence of showing by insurance carrier that its actions come within exceptions to liability for such fees and penalty.

No "formal" demand on insurer need be made, and where there was evidence in the record from which the court could have concluded that an informal demand was made the insured was not precluded from obtaining the statutory penalty and attorney's fees. *Farm Bureau Mut. Ins. Co. v. Shaw*, 269 Ark. 757, 600 S.W.2d 432 (Ct. App. 1980).

No demand other than the filing of a suit is required under this section; moreover, a new and lesser demand may be made by amendment after suit is filed, and the surety's liability for the statutory penalty will be determined by whether it elects to contest the claim rather than offering to pay the reduced amount or asking for time in which to pay. *R.J. "Bob" Jones Excavating Contractor v. Firemen's Ins. Co.*, 324 Ark. 282, 920 S.W.2d 483 (1996).

There is no requirement that formal demand for payment be made; it is sufficient to show that the insurer was put on notice that payment under the policy was due. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 67 Ark. App. 347, 1 S.W.3d 452 (1999).

Excess Liability Carriers.

This section applies to bar an award of attorneys' fees to an excess liability carrier in the defense of a case where the insurer is found not liable for a loss. *Employers Surplus Ins. Co. v. Murphy Oil USA, Inc.*, 338 Ark. 299, 993 S.W.2d 481 (1999).

Insurer's Liability.

Insurer held liable for statutory penalty and/or attorney's fees. *Queen of Ark. Ins. Co. v. Taylor*, 100 Ark. 9, 138 S.W. 990 (1911); *New York Life Ins. Co. v. Adams*, 151 Ark. 123, 235 S.W. 412 (1921); *Home Life & Accident Co. v. Scheuer*, 162 Ark. 600, 258 S.W. 648 (1924); *Continental Life Ins. Co. v. Gray*, 188 Ark. 65, 64 S.W.2d 554 (1933); *American Nat'l Ins. Co. v. Westerfield*, 189 Ark. 476, 73 S.W.2d 155 (1934); *Home Life Ins. Co. v. Ward*, 189 Ark. 793, 75 S.W.2d 379 (1934); *Morrison-Knudsen Co. v. Phoenix Ins. Co.*, 172 F.2d 124 (8th Cir. 1949) (preceding decisions under prior law); *Lewis v. Goldsborough*, 234 F. Supp. 524 (E.D. Ark. 1964); *Lawrence v. Providential Life Ins. Co.*, 238 Ark. 981, 385 S.W.2d 936 (1965); *Trinity Universal Ins. Co. v. Stobaugh*, 239 Ark. 746, 395 S.W.2d 24 (1965); *Whitfield v. Metropolitan Life Ins. Co.*, 262 F. Supp. 977 (W.D. Ark. 1967); *Tri-State Ins. Co. v. Smith*, 248 Ark. 71, 449 S.W.2d 698 (1970); *Haskins v. Occidental Life Ins. Co.*, 349 F. Supp. 1192 (E.D. Ark. 1972); *Home Ins. Co. v. Crawford*, 251 Ark. 843, 475 S.W.2d 889 (1972); *Blevins v. Commercial Std. Ins. Cos.*, 544 F.2d 967 (8th Cir. 1976); *Southern Farm Bureau Cas. Ins. Co. v. Gooding*, 263 Ark. 435, 565 S.W.2d 421 (1978); *Farmers Mut. Ins. Co. v. Lane*, 278 Ark. 53, 643 S.W.2d 544 (1982); *Stuckey v. Time Ins. Co.*, 669 F. Supp. 261 (E.D. Ark. 1987), aff'd, 860 F.2d 1084 (8th Cir. 1988); *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988); *Shepherd v. State Auto Property & Cas. Ins. Co.*, 312 Ark. 502, 850 S.W.2d 324 (1993).

For cases concerning insurer's liability where suicide or murder may be involved, see, *Fidelity & Cas. Co. v. Meyer*, 106 Ark. 91, 152 S.W. 995 (1912); *Guardian Life Ins. Co. v. Dixon*, 152 Ark. 597, 240 S.W. 25 (1922) (preceding decisions under prior law); *Clark Ctr., Inc. v. National Life & Accident Ins. Co.*, 245 Ark. 563, 433 S.W.2d 151 (1968); *Clark v. New York Life Ins. Co.*, 245 Ark. 763, 434 S.W.2d 611 (1968); *Clark v. Paul Revere Life Ins. Co.*, 417 F.2d 683 (8th Cir. 1969); *Fisk v. Security Life & Trust Co.*, 575 F.2d 1242 (8th Cir. 1978).

Where the defendant insurance company failed to pay a loss accruing under a parol agreement, the company was not liable for the statutory penalty and attorney's fees. *Aetna Ins. Co. v. Short*, 124 Ark.

505, 187 S.W. 657 (1916); *Carolina Cas. Ins. Co. v. Helms*, 248 F.2d 268 (8th Cir. 1957) (preceding decisions under prior law).

There was no liability where the beneficiary sued for more than the face value of the policy which was tendered before and accepted after the suit was brought. *Illinois Bankers' Life Ass'n v. Mann*, 158 Ark. 425, 250 S.W. 887 (1923) (decision under prior law).

Insurer held not liable for penalty and/or attorney's fees. *American Alliance Ins. Co. v. Paul*, 173 Ark. 960, 294 S.W. 58 (1927); *National Old Line Ins. Co. v. Russell*, 188 Ark. 632, 67 S.W.2d 195 (1934); *Papan v. Resolute Ins. Co.*, 219 Ark. 907, 245 S.W.2d 565 (1952); *Tollett v. Phoenix Assurance Co.*, 147 F. Supp. 597 (W.D. Ark. 1956); *Equitable Life Assurance Soc'y v. Hughes*, 152 F. Supp. 187 (E.D. Ark. 1957); *Little Rock Packing Co. v. Massachusetts Bonding & Ins. Co.*, 262 F.2d 327 (8th Cir. 1959) (preceding decisions under prior law); *Callum v. Farmers Union Mut. Ins. Co.*, 256 Ark. 376, 508 S.W.2d 316 (1974); *Hill's Co-op. Gin Co. v. Bullington*, 261 Ark. 915, 552 S.W.2d 231 (1977); *Farm Bureau Ins. Co. v. Paladino*, 264 Ark. 311, 571 S.W.2d 86 (1978); *McKee v. Federal Kemper Life Assurance Co.*, 726 F. Supp. 245 (E.D. Ark. 1989), *aff'd*, 927 F.2d 326 (8th Cir. 1991).

Where insurer acted expeditiously and in good faith in ascertaining its liability, the insured was not entitled to recover the statutory penalty and attorney's fees. *Missouri State Life Ins. Co. v. King*, 186 Ark. 983, 57 S.W.2d 400 (1933); *Taylor v. Mutual Life Ins. Co.*, 193 Ark. 251, 98 S.W.2d 944 (1936) (preceding decisions under prior law); *Clark v. New York Life Ins. Co.*, 245 Ark. 763, 434 S.W.2d 611 (1968). But see, *Life & Cas. Ins. Co. v. Wiggins*, 224 Ark. 377, 273 S.W.2d 405 (1954); *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955); *Willis-Reed Lumber Co. v. New York Underwriters Ins. Co.*, 146 F. Supp. 74 (W.D. Ark. 1956); *Tollett v. Phoenix Assurance Co.*, 147 F. Supp. 597 (W.D. Ark. 1956) (preceding decisions under prior law).

Insurer shall have a reasonable time to make necessary investigation in reference to the loss and the circumstances thereof after demand. *Taylor v. Mutual Life Ins. Co.*, 193 Ark. 251, 98 S.W.2d 944 (1936);

Clark v. New York Life Ins. Co., 245 Ark. 763, 434 S.W.2d 611 (1968) (decision under prior law).

An insured may be entitled to the statutory penalty and attorney's fee even if the insurer has paid the claim to the insured. *Farm Bureau Mut. Ins. Co. v. Shaw*, 269 Ark. 757, 600 S.W.2d 432 (Ct. App. 1980).

When an insurer cancels a liability policy for nonpayment of premium and so notifies the insured prior to an accident, the insurer is not liable. *State Farm Mut. Auto. Ins. Co. v. Abercrombie*, 212 Ark. 855, 208 S.W.2d 170 (1948) (decision under prior law).

This section does not contemplate the awarding of a contingent fee against the insurer. *Southern Farm Bureau Life Ins. Co. v. Cowger*, 295 Ark. 250, 748 S.W.2d 332 (1988).

Where plaintiffs suffer no loss and do not recover a money judgment, they are not entitled to a 12% penalty under this section. *Shelter Mut. Ins. Co. v. Smith*, 300 Ark. 348, 779 S.W.2d 149 (1989).

Failure to pay a claim within 60 days of receipt of proof of loss does not result in automatic liability under the penal provisions of this section; an insurer has a reasonable time to investigate a claim, and what is reasonable depends on the facts and circumstances of the case. *McKee v. Federal Kemper Life Assurance Co.*, 726 F. Supp. 245 (E.D. Ark. 1989), *aff'd*, 927 F.2d 326 (8th Cir. 1991).

Where an insured loss occurs and an insurance company fails to pay the loss within the time specified in the policy, then the insurance company is required to pay, in addition to the loss, a 12% penalty plus reasonable attorneys' fees; the fact that the insurance company later pays the claim does not defeat the award of penalty and attorney's fees for it is well settled that attorney's fees and penalty attach if the insured is required to file suit, even though judgment is confessed before trial. *Silvey Cos. v. Riley*, 318 Ark. 788, 888 S.W.2d 636 (1994).

Where insurer had full knowledge of the family dispute and set a deadline for the parties to resolve their differences, and where the insurer failed to take any action until after the deadline had passed, after the expiration of the sixty-day limit of § 23-81-113(b), and after one of the claimant's filed suit, insurer was liable for the

penalties prescribed by subsection (a) of this section. *Minnesota Mut. Life Ins. Co. v. Looney*, 55 Ark. App. 384, 935 S.W.2d 3 (1996).

Under-insured motorist insurance carrier was liable to its policy holder for attorney fees under this section because the amount recovered was within twenty percent of the \$75,000 demanded in the amended complaint; because the policy holder amended his complaint, he was not tied to the \$100,000 demand in the original complaint. *S. Farm Bureau Cas. Ins. Co. v. Brinker*, 350 Ark. 15, 84 S.W.3d 846 (2002).

Insurer's Rights.

The insurer held to have a right to demand proof of a fire loss without becoming liable to the statutory penalty and attorney's fee. *North British & Mercantile Ins. Co. v. Equitable Bldg. & Loan Ass'n*, 185 Ark. 476, 47 S.W.2d 797 (1932) (decision under prior law).

Given that this section allows attorney's fees to insureds under prescribed circumstances, but omits any reference to such fee awards to insurers, the statute does not allow an award of attorney's fees to an insurer who prevails in an action by an insured seeking recovery for a claim under a policy. *Village Mkt., Inc. v. State Farm Gen. Ins. Co.*, 334 Ark. 227, 975 S.W.2d 86 (1998).

Interest.

The statutory penalty is assessed in addition to interest. *Maryland Cas. Co. v. Maloney*, 119 Ark. 434, 178 S.W. 387 (1915) (decision under prior law).

There is no conflict in the awarding of pre-judgment interest pursuant to § 23-81-118 and, in addition, awarding a statutory penalty and attorney's fees pursuant to this section. *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988).

Prejudgment interest is based upon an improperly disallowed insurance claim. Where the trial court's decision to award the proceeds of the policy to the estate is reversed, the estate's argument for a statutory penalty and prejudgment interest has no basis. *First Pyramid Life Ins. Co. of Am. v. Stoltz*, 311 Ark. 313, 843 S.W.2d 842 (1992), cert. denied, 510 U.S. 908, 114 S. Ct. 290, 126 L. Ed. 2d 239 (1993).

Jurisdiction.

The penalty and attorney's fee provided

for is collectible in chancery court as well as in any other court. *Bankers' Reserve Life Co. v. Crowley*, 171 Ark. 135, 284 S.W. 4 (1926) (decision under prior law).

A justice of the peace has jurisdiction to recover on insurance policy and in addition thereto the statutory penalty and attorney's fee. *American Liberty Mut. Ins. Co. v. Washington*, 183 Ark. 497, 36 S.W.2d 963 (1931) (decision under prior law).

Penalty and attorney's fees included in amount in controversy for jurisdictional purposes. *Missouri State Life Ins. Co. v. Jones*, 290 U.S. 199, 54 S. Ct. 133, 78 L. Ed. 267 (1933); *Pacific Mut. Life Ins. Co. v. Bierman*, 188 Ark. 703, 67 S.W.2d 577 (1934); *American United Life Ins. Co. v. Franklin*, 97 F.2d 76 (8th Cir. 1938) (preceding decisions under prior law); *State Farm Mut. Auto. Ins. Co. v. Pennington*, 215 F. Supp. 784 (E.D. Ark. 1963), aff'd, 324 F.2d 340 (8th Cir. 1963); *Wortman v. Safeco Ins. Co. of Am.*, 227 F. Supp. 468 (E.D. Ark. 1963); *Peacock & Peacock, Inc. v. Stuyvesant Ins. Co.*, 332 F.2d 499 (8th Cir. 1964); *Combined Ins. Co. of Am. v. Dreyfus*, 244 Ark. 1011, 428 S.W.2d 239 (1968).

The penalty and reasonable attorney's fees under this section do not come within the purview of the "interest and costs" exclusion referred to in the federal diversity statute. *Halter v. National Farmers Union Property & Cas. Co.*, 502 F. Supp. 736 (E.D. Ark. 1980).

Statutory penalty and attorney's fee have been allowed in only those cases having a connection with the State of Arkansas. *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988).

Liability.

Surety was not liable to subcontractor on complaint for nonpayment under a statutory payment bond because of litigation between subcontractor and general contractor. *R.J. "Bob" Jones Excavating Contractor v. Firemen's Ins. Co.*, 324 Ark. 282, 920 S.W.2d 483 (1996).

Loss-Payees.

The statute does not limit recovery of penalties and fees to just the holder of an insurance policy, but also permits recovery by a loss-payee under the policy. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 341 Ark. 181, 15 S.W.3d 328 (2000).

Parties Protected.

Beneficiaries, as well as an assignee holding a life policy as collateral, were holders of the policy within the meaning of former section. *Huddleston v. Home Life Ins. Co.*, 182 Ark. 1036, 34 S.W.2d 221 (1931) (decision under prior law).

The person having exercised his right to sue, although not the insured, is the "holder" under the section to whom a surety must pay penalties and attorney fees for failure to pay when legally liable. *United States ex rel. Magnolia Petro. Co. v. H.R. Henderson & Co.*, 126 F. Supp. 626 (W.D. Ark. 1955) (decision under prior law).

Where bank took out additional fire insurance on home of insureds, the additional insurance insured to the benefit of insureds upon payment of the bank loan, and, after destruction of the insured property by fire, insureds were entitled to recover the face amount of the policy issued to the bank, less the unpaid premium instalment plus penalty and a reasonable attorney's fee. *Mann v. Charter Oak Fire Ins. Co.*, 196 F. Supp. 604 (E.D. Ark. 1961), *aff'd*, 304 F.2d 166 (8th Cir. 1962).

Where, against insurance company's action for declaratory judgment of nonliability, driver of car which injured a party filed a counterclaim seeking the allowance of a 12 percent penalty and an attorney's fee, the counterclaim was denied, as he paid no part of the injured party's judgment and did not obtain any monetary award in the instant case. *State Farm Mut. Auto. Ins. Co. v. Pennington*, 215 F. Supp. 784 (E.D. Ark. 1963), *aff'd*, 324 F.2d 340 (8th Cir. 1963).

Where nephew and uncle lived under same roof and were members of another's household, but there was an absence of evidence showing any particular familial closeness, insurance company was liable under its policy due to provision excluding liability for bodily injury to the insured or any member of the family of the insured residing in the same household as the insured. *State Farm Mut. Auto. Ins. Co. v. Pennington*, 215 F. Supp. 784 (E.D. Ark. 1963), *aff'd*, 324 F.2d 340 (8th Cir. 1963).

Excess insurer which defended action was entitled to recover from owner's insurer the legal expenses incurred in defending minor who was held to be an insured under owner's liability policy.

Blevins v. Commercial Std. Ins. Cos., 544 F.2d 967 (8th Cir. 1976).

Argument that the insured should not be entitled to the penalty and fee because the insurer had no obligation to pay the insured any money, as all of it was to go to mortgagee, and that the insured obtained no benefit from the payment and had no interest which should be protected by this section was incorrect and insured was entitled to such penalty and fee. *Farm Bureau Mut. Ins. Co. v. Shaw*, 269 Ark. 757, 600 S.W.2d 432 (Ct. App. 1980).

It does not matter whether the actual payment under the policy is made to the insured or to the loss payee in order for the insureds to be entitled to the statutory penalty and attorneys' fees when payment by the insurer is late. *Farmers Mut. Ins. Co. v. Lane*, 278 Ark. 53, 643 S.W.2d 544 (1982).

Passenger injured in automobile accident could not recover attorneys' fees and expenses from insurer for failure to pay the limits of uninsured motorists policy where passenger was not entitled to recover under such policy. *Williams v. State Farm Mut. Auto. Ins. Co.*, 737 F.2d 741 (8th Cir. 1984), *cert. denied*, 469 U.S. 1159, 105 S. Ct. 910, 83 L. Ed. 2d 923, rehearing denied, 470 U.S. 1039, 105 S. Ct. 1414, 84 L. Ed. 2d 800 (1985).

A party who prevails under the subrogation statute, § 23-89-101, may, in some circumstances, be entitled to the statutory penalty and attorney's fee under this section. *Simmons First Nat'l Bank v. Liberty Mut. Ins. Co.*, 282 Ark. 194, 667 S.W.2d 648 (1984).

In an action commenced by an insurance company seeking a declaratory judgment that it owed nothing under a motor vehicle policy, the defendant financial institution, which had loaned money to the insured to purchase the vehicle, and which filed a successful counterclaim seeking the policy proceeds, was entitled to recover attorney's fees under the statute. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 67 Ark. App. 347, 1 S.W.3d 452 (1999).

The trial court did not err in its finding that a mortgagee had an interest in insurance proceeds and the penalties enumerated in the statute when, after a fire loss, she received and accepted a quitclaim deed to the property from the mortgagor in full satisfaction of the the mortgagee's underlying debt contained in the parties'

real estate contract; the quitclaim deed constituted a release of the mortgagor by the mortgagee from all obligations under the parties' real estate contract and, therefore, the mortgagor conveyed all of her interest in the insurance proceeds and lost her status as an assignee as she had no insurable interest. *Bunn v. Luthultz*, 70 Ark. App. 26, 13 S.W.3d 915 (2000).

Receivership.

Where claimants did not sue until receiver was appointed and then voluntarily intervened in receivership proceeding in chancery court, they were not entitled to the penalty and attorney's fees. *Federal Union Sur. Co. v. Flemister*, 95 Ark. 389, 130 S.W. 574 (1910) (decision under prior law).

Damages and attorney's fee could not be recovered in a case where proof of loss was made after the company was placed in the hands of a receiver. *Massachusetts Bonding & Ins. Co. v. Home Life & Accident Co.*, 119 Ark. 102, 178 S.W. 314 (1915) (decision under prior law).

Recovery on Principal Claim.

For cases decided prior to 1991 amendment holding that insured was not entitled to recover a penalty and attorney's fee where he failed to recover full amount sued for, see *Pacific Mut. Life Ins. Co. v. Carter*, 92 Ark. 378, 123 S.W. 384 (1909); *Fidelity Phenix Fire Ins. Co. v. Roth*, 164 Ark. 608, 262 S.W. 643 (1924); *Lincoln Reserve Life Ins. Co. v. Jones*, 178 Ark. 466, 10 S.W.2d 910 (1928); *National Union Fire Ins. Co. v. Bynum*, 183 Ark. 1100, 40 S.W.2d 446 (1931); *Detroit Fire & Marine Ins. Co. v. Helms*, 184 Ark. 308, 42 S.W.2d 394 (1931); *Mutual Life Ins. Co. v. Marsh*, 186 Ark. 861, 56 S.W.2d 433 (1933); *Service Fire Ins. Co. v. Horn*, 202 Ark. 300, 150 S.W.2d 53 (1941); *Liverpool & London & Globe Ins. Co. v. Jones*, 207 Ark. 237, 180 S.W.2d 519 (1944); *Good Canning Co. v. London Guarantee & Accident Co.*, 128 F. Supp. 778 (W.D. Ark. 1955); *Southern Farm Bureau Cas. Ins. Co. v. Reed*, 231 Ark. 759, 332 S.W.2d 615 (1960) (preceding decisions under prior law); *Alexander v. Pilot Fire & Cas. Ins. Co.*, 331 F. Supp. 561 (E.D. Ark. 1971); *Cassady v. United Ins. Co. of Am.*, 370 F. Supp. 388 (W.D. Ark. 1974); *Highlands Ins. Co. v. William Burris Masonry Contractors, Inc.*, 258 Ark. 694, 528 S.W.2d 405 (1975); *MFA*

Mut. Ins. Co. v. Keller, 274 Ark. 281, 623 S.W.2d 841 (1981); *Bank of Mulberry v. Fireman's Fund Ins. Co.*, 550 F. Supp. 1218 (W.D. Ark. 1982), reversed on other grounds, 720 F.2d 501 (8th Cir. 1983); *Hill v. Farmers Union Mut. Ins. Co.*, 15 Ark. App. 222, 691 S.W.2d 196 (1985).

For cases decided prior to the 1991 amendment, holding that insured was entitled to penalty and attorney's fee as having recovered full amount demanded on principal claim, see *Queen of Ark. Ins. Co. v. Millham*, 102 Ark. 675, 145 S.W. 540 (1912); *Queen of Ark. Ins. Co. v. Bramlett*, 103 Ark. 1, 145 S.W. 541 (1912) (decision under prior law); *Kansas City Fire & Marine Ins. Co. v. Epperson*, 234 Ark. 1100, 356 S.W.2d 613 (1962); *Smith v. Beall*, 248 Ark. 248, 451 S.W.2d 195 (1970); *Farm Bureau Mut. Ins. Co. v. Mitchell*, 249 Ark. 127, 458 S.W.2d 395 (1970); *Alexander v. Pilot Fire & Cas. Ins. Co.*, 331 F. Supp. 561 (E.D. Ark. 1971); *Woods v. Commercial Union Ins. Co. of Am.*, 336 F. Supp. 494 (W.D. Ark. 1971); *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988).

Where the plaintiffs recover the full amount of the policy covering the property insured, they are entitled to the statutory penalty and attorney's fees. *Featherston v. Hartford Fire Ins. Co.*, 146 F. Supp. 535 (W.D. Ark. 1956).

For cases decided prior to the 1991 amendment holding that the insured was not entitled to penalty and attorney's fees because of failure to recover full amount demanded or principal claim, see *Kansas City Fire & Marine Ins. Co. v. Baker*, 229 Ark. 130, 313 S.W.2d 846 (1958) (decision under prior law); *Southern Farm Bureau Cas. Ins. Co. v. Brigrance*, 234 Ark. 172, 351 S.W.2d 417 (1961); *Smith v. United States Fid. & Guar. Co.*, 239 Ark. 984, 395 S.W.2d 749 (1965); *Ford Life Ins. Co. v. Jones*, 262 Ark. 881, 563 S.W.2d 399 (1978), overruled on other grounds, *Southern Farm Bureau Life Ins. Co. v. Cowger*, 295 Ark. 250, 748 S.W.2d 332 (1988); *Red Lobster Inns of Am., Inc. v. Lawyers Title Ins. Corp.*, 492 F. Supp. 933 (E.D. Ark. 1980), aff'd, 656 F.2d 381 (8th Cir. 1981); *Countryside Cas. Co. v. Grant*, 269 Ark. 526, 601 S.W.2d 875 (1980); *Bank of Mulberry v. Fireman's Fund Ins. Co.*, 720 F.2d 501 (8th Cir. 1983).

A new and lesser demand may be made by amendment after suit is filed in which

event if the insurer offers to pay the reduced amount, or asks for time in which to pay, there can be no recovery of the penalty. But when insurer elects "to go on and contest the claim on other grounds," and there is a recovery for the amount sued for (or, now, within 20% of the amount demanded or sought in the suit) it becomes liable under this section for the penalty and attorney fee. *United States ex rel. Peevy v. Pensacola Constr. Co.*, 257 F. Supp. 131 (W.D. Ark. 1966).

Where insurer resisted its obligation without wilful wrong so that claimant lost his claim for exemplary damage, he was thereby also precluded from attorney's fees. *Cassady v. United Ins. Co. of Am.*, 370 F. Supp. 388 (W.D. Ark. 1974).

It is within the trial court's discretion to permit amendment of the complaint by plaintiff during trial or amendment of the complaint to conform to the proof, and, if the sum finally sued for is awarded (or, now, within 20% of the sum finally sued for is awarded), attorneys' fees and penalties are proper. *Bank of Mulberry v. Fireman's Fund Ins. Co.*, 550 F. Supp. 1218 (W.D. Ark. 1982), rev'd on other grounds, 720 F.2d 501 (8th Cir. 1983).

In order for an insured to be entitled to a 12 percent and attorney's fees pursuant to this section, the plaintiff must recover the exact amount claimed. *Security Ins. Corp. v. Henley*, 19 Ark. App. 299, 720 S.W.2d 328 (1986) (decision prior to 1991 amendment).

—Reduction of Claim.

Where plaintiff suffered a loss by fire and agreed with the adjuster of the company in which he held a policy as to the amount of damage sustained, but later the company denied all liability, and thereafter plaintiff recovered judgment for the amount, he was entitled to attorney's fees and the statutory penalty although he originally sued for a greater amount. *Great S. Fire Ins. Co. v. Burns & Billington*, 118 Ark. 22, 175 S.W. 1161 (1915) (decision under prior law).

Where insured amends his complaint to reduce amount claimed and insurer continues to deny liability, or fails to confess judgment for the lesser amount, statutory penalty and attorney's fees may be assessed against insurer. *Life & Cas. Co. v. Sanders*, 173 Ark. 362, 292 S.W. 657 (1927); *Pacific Mut. Life Ins. Co. v.*

McCombs, 188 Ark. 52, 64 S.W.2d 333 (1933), cert. denied, 292 U.S. 624, 54 S. Ct. 628, 78 L. Ed. 1479 (1934); *Progressive Life Ins. Co. v. Hulbert*, 196 Ark. 352, 118 S.W.2d 268 (1938); *Kansas City Fire & Marine Ins. Co. v. Kellum*, 221 Ark. 487, 254 S.W.2d 50 (1953); *Farmers Union Mut. Ins. Co. v. Myers*, 234 Ark. 1061, 356 S.W.2d 423 (1962); *Old Am. Life Ins. Co. v. McKenzie*, 240 Ark. 984, 403 S.W.2d 94 (1966) (preceding decisions under prior law).

An insurance company is not liable for the statutory penalty and attorney's fees where the insured, after claiming a certain amount, sued for a smaller amount (now, an amount not within 20% of the amount demanded or sued for) which the insurance company promptly paid. *National Fire Ins. Co. v. Kight*, 185 Ark. 386, 47 S.W.2d 576 (1932) (decision under prior law).

Where the insured sues for an amount less than previously demanded, when the suit itself constitutes the original demand, or when he amends his complaint to sue for a lesser amount, and the insurance company confesses liability for the amount sued for (now, an amount not within 20% of the amount demanded or sued for), then the insured is not entitled to the allowance of a penalty or to an attorney's fee. *Tollett v. Phoenix Assurance Co.*, 147 F. Supp. 597 (W.D. Ark. 1956) (decision under prior law); *Armco Steel Corp. v. Ford Constr. Co.*, 237 Ark. 272, 372 S.W.2d 630 (1963).

The plaintiffs recovered within 20 percent of the money demanded, notwithstanding that they sought their policy limits and that the judgment recovered by them was set off by monies paid to two banks for a mortgage and a lien on a vehicle. *Farm Bureau Mut. Ins. Co. v. Foote*, 341 Ark. 105, 14 S.W.3d 512 (2000).

—Untimely Payment of Claim.

Where it was not reasonably necessary for the insurance company to continue to investigate the case for more than 60 days after the proof of loss was submitted, the time limit in the policy, the trial court properly awarded interest and attorney's fees to the insured after the insurer failed to timely pay the claim. *Silvey Cos. v. Riley*, 318 Ark. 788, 888 S.W.2d 636 (1994).

State's Authority.

Former section was not an arbitrary

and unjust classification of insurance companies but is a valid exercise of the state's police power. *Arkansas Ins. Co. v. McManus*, 86 Ark. 115, 110 S.W. 797 (1908) (decision under prior law).

Tort Actions.

In a suit against an insurance carrier to recover damages in excess of the policy limits, with such action sounding in tort and not *ex contractu*, the plaintiff was not entitled to the 12% penalty, reasonable attorney's fee, or interest from the date of the original judgment. *Tri-State Ins. Co. v. Busby*, 251 Ark. 568, 473 S.W.2d 893 (1971).

Neither the Trade Practices Act (§ 23-66-201 et seq.), nor the penalty and fees provisions of this section preempt the area upon which the tort of bad faith is founded. *Aetna Cas. & Sur. Co. v. Broadway Arms Corp.*, 281 Ark. 128, 664 S.W.2d 463 (1984).

The tort of bad faith against an insurance company has not been preempted by this section and by the comprehensive statutory scheme for regulation of the insurance business. *Employers Equitable Life Ins. Co. v. Williams*, 282 Ark. 29, 665 S.W.2d 873 (1984).

Cited: *State Farm Mut. Auto. Ins. Co. v. Pennington*, 324 F.2d 340 (8th Cir. 1963); *Millers Mut. Fire Ins. Co. v. Russell*, 246 Ark. 1295, 443 S.W.2d 536 (1969); *Bryan v. Aetna Cas. & Sur. Co.*, 381 F.2d 872 (8th Cir. 1967); *Phillips ex rel. Phillips v. Midwest Mut. Ins. Co.*, 329 F. Supp. 853 (W.D. Ark. 1971); *Howard v. Grain Dealers Mut. Ins. Co.*, 342 F. Supp. 1125 (W.D. Ark. 1972); *Southwestern Ins. Co. v. Camp*, 253 Ark. 886, 489 S.W.2d 498 (1973); *Vern Barnett Constr. Co. v. J.A. Hadley Constr.*

Co., 254 Ark. 866, 496 S.W.2d 446 (1973); *Thomas v. Williford*, 259 Ark. 354, 534 S.W.2d 2 (1976); *Grady-Gould Watershed Imp. Dist. v. Transamerican Ins. Co.*, 570 F.2d 720 (8th Cir. 1978); *Robinson v. MFA Mut. Ins. Co.*, 629 F.2d 497 (8th Cir. 1980); *Old Am. Ins. Co. v. Williamson*, 268 Ark. 907, 597 S.W.2d 118 (Ct. App. 1980); *Jackson v. Prudential Ins. Co. of Am.*, 564 F. Supp. 229 (W.D. Ark. 1983); *Atlas Carriers, Inc. v. Transport Ins. Co.*, 584 F. Supp. 50 (E.D. Ark. 1983); *Bullock v. State Farm Mut. Auto. Ins. Co.*, 733 F.2d 63 (8th Cir. 1984); *Kay v. Economy Fire & Cas. Co.*, 284 Ark. 11, 678 S.W.2d 365 (1984); *Farmers Ins. Co. v. Shuffield*, 284 Ark. 158, 680 S.W.2d 96 (1984); *Bell v. Kansas City Fire & Marine Ins. Co.*, 616 F. Supp. 1305 (W.D. Ark. 1985); *Metropolitan Property & Liab. Ins. Co. v. Stancel*, 16 Ark. App. 91, 697 S.W.2d 923 (1985); *Glenn v. Farmers & Merchants Ins. Co.*, 649 F. Supp. 1447 (W.D. Ark. 1986); *D'Onofrio v. Travelers Ins. Co.*, 662 F. Supp. 872 (E.D. Ark. 1987); *Woolsey v. Nationwide Ins. Co.*, 697 F. Supp. 1053 (W.D. Ark. 1988); *Northwestern Nat'l Life Ins. Co. v. Heslip*, 302 Ark. 310, 790 S.W.2d 152 (1990); *Mid-Century Ins. Co. v. Anderson*, 303 Ark. 54, 791 S.W.2d 706 (1990); *Ferrell v. Columbia Mut. Ins. Cas. Co.*, 306 Ark. 533, 816 S.W.2d 593 (1991); *State Farm Mut. Auto. Ins. Co. v. Thomas*, 312 Ark. 429, 850 S.W.2d 4 (1993); *Mountain Home Sch. Dist. No. 9 v. T.M.J. Bldrs., Inc.*, 313 Ark. 661, 858 S.W.2d 74 (1993); *State Farm Mut. Auto. Ins. Co. v. Brown*, 48 Ark. App. 136, 892 S.W.2d 519 (1995); *Shelter Mut. Ins. Co. v. Kennedy*, 347 Ark. 184, 60 S.W.3d 458 (2001); *Capital Life & Accident Ins. Co. v. Phelps*, 76 Ark. App. 428, 66 S.W.3d 678 (2002).

23-79-209. Allowance of attorney's fees in suits to terminate, modify, or reinstate policy.

(a) In all suits in which the judgment or decree of a court is against a life, property, accident and health, or liability insurance company, either in a suit by it to cancel or lapse a policy or to change or alter the terms or conditions thereof in any way that may have the effect of depriving the holder of the policy of any of his or her rights thereunder, or in a suit for a declaratory judgment under the policy, or in a suit by the holder of the policy to require the company to reinstate the policy, the company shall also be liable to pay the holder of the policy all reasonable attorney's fees for the defense or prosecution of the suit, as the case may be.

(b) The fees shall be based on the face amount of the policy involved.

(c) The attorney's fees shall be taxed by the court where the suit is heard on original action, by appeal or otherwise, and shall be taxed up as a part of the costs therein and collected as other costs are or may be by law collected.

History. Acts 1959, No. 148, § 306; A.S.A. 1947, § 66-3239; Acts 2001, No. 1604, § 114.

Amendments. The 2001 amendment

substituted "property, accident and health, or" for "fire, health, accident, or" in (a).

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1990 Insurance Law Decisions, 1991 Ark. L. Notes 75.

UALR L.J. Bassett, Survey of Arkansas Law: Insurance, 2 UALR L.J. 247.

Seventeenth Annual Survey of Arkansas Law — Insurance, 17 UALR L.J. 451.

CASE NOTES

ANALYSIS

Construction.

Purpose.

Applicability.

Allowance.

Amount.

Counterclaim for policy proceeds.

Declaratory judgment.

Dismissal with prejudice.

Holder of policy.

Penalty.

Reasonable fees.

Construction.

This section is penal in nature and is to be construed strictly. *State Farm Mut. Auto. Ins. Co. v. Pennington*, 215 F. Supp. 784 (E.D. Ark. 1963), *aff'd*, 324 F.2d 340 (8th Cir. 1963).

Purpose.

The intent of this section was to amend prior law by providing an attorney's fee when the insured prevails in a controversy with his insurance company, but does not actually obtain a money judgment against it; therefore where insured brought suit to recover proceeds on an insurance policy and recovered a money judgment this section did not apply and insured could not be awarded attorney's fees. *DeFranco v. Valley Forge Ins. Co.*, 754 F.2d 293 (8th Cir. 1985).

Applicability.

Former section did not apply to suits for

the recovery of premiums paid upon a policy wrongfully cancelled. *American Republic Life Ins. Co. v. Claybough*, 227 Ark. 946, 302 S.W.2d 545 (1957) (decision under prior law).

This section specifically applies to declaratory judgment actions, and excludes the allowance of a penalty, although providing for an award of attorney's fees. *Silverball Amusement, Inc. v. Utah Home Fire Ins. Co.*, 842 F. Supp. 1151 (W.D. Ark.), *aff'd*, 33 F.3d 1476 (8th Cir. 1994).

This section applies only in suits to terminate, modify, or reinstate a policy. *State Farm Mut. Auto. Ins. Co. v. Brown*, 48 Ark. App. 136, 892 S.W.2d 519 (1995).

Allowance.

Insureds held entitled to recover in the declaratory action a reasonable fee for the services of their attorneys. *Broyles v. Commercial Union Ins. Co.*, 287 F. Supp. 942 (W.D. Ark. 1968).

Where insurance company brought suit for declaratory judgment seeking to deprive defendant of the benefits of insurance policy issued to defendant's decedent, defendant was entitled to a reasonable attorney's fee and costs of the defense of the action. *Eagle Star Ins. Co. v. Deal*, 337 F. Supp. 1264 (W.D. Ark. 1972), *rev'd on other grounds*, 474 F.2d 1216 (8th Cir. 1973).

Language of this section does not encompass recovery of attorney's fees by

principal who prevailed in action by surety to recover amount of claim. *Fireman's Fund Ins. Co. v. Clark*, 253 Ark. 1025, 490 S.W.2d 447 (1973).

Attorney's fees are not allowed as part of damages where plaintiff fails to recover in his suit the entire amount sued for. *Cassady v. United Ins. Co. of Am.*, 370 F. Supp. 388 (W.D. Ark. 1974).

Mayor charged with having deprived political opponents of their civil rights by making allegedly false and discriminatory statements was awarded attorney fees under this section, where his insurer unsuccessfully appealed a lower court decision ordering it to defend mayor under personal injury policy covering actions for libel or slander, despite insurer's contention that the civil rights action fell outside the scope of a libel or slander suit. *Ritter v. United States Fid. & Guar. Co.*, 573 F.2d 539 (8th Cir. 1978).

In a declaratory judgment action, the awarding of attorney fees is proper only under this section, which does not provide for the 12% penalty set forth in § 23-79-208. Therefore, the trial judge does not err in refusing to assess the 12% penalty. *Shelter Mut. Ins. Co. v. Smith*, 300 Ark. 348, 779 S.W.2d 149 (1989).

Amount.

Where plaintiff is entitled to recover a reasonable attorney's fee, but there is no testimony as to the amount of such fee, the court may fix the fee upon the record before it. *Curran v. Security Ins. Co.*, 195 F. Supp. 562 (W.D. Ark. 1961), appeal dismissed, 296 F.2d 733 (8th Cir. 1961).

The right to fix the fee granted by this section is either in the trial court or the appellate court, and, therefore, where insured successfully brought suit asking among other things to be allowed an attorney fee and the trial court erroneously denied this prayer, the appellate court would set the fee for services in trial and appellate courts. *Maryland Cas. Co. v. Turner*, 235 Ark. 718, 361 S.W.2d 646 (1962).

The determination of the amount of reasonable attorney's fees depends largely upon the circumstances of the particular case. *Eagle Star Ins. Co. v. Deal*, 337 F. Supp. 1264 (W.D. Ark. 1972), rev'd on other grounds, 474 F.2d 1216 (8th Cir. 1973).

Counterclaim for Policy Proceeds.

Section 23-79-208, rather than this sec-

tion, applied to an action commenced by an insurance company seeking a declaratory judgment that it owed nothing under a motor vehicle policy, where the defendant financial institution (which had loaned money to the insured to purchase the vehicle) filed a counterclaim seeking the policy proceeds and was successful on that counterclaim. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 67 Ark. App. 347, 1 S.W.3d 452 (1999).

Declaratory Judgment.

In a declaratory judgment action, the awarding of attorney's fees is proper under this section, which does not provide for the 12% penalty set forth in § 23-79-208. *Silverball Amusement, Inc. v. Utah Home Fire Ins. Co.*, 842 F. Supp. 1151 (W.D. Ark.), aff'd, 33 F.3d 1476 (8th Cir. 1994).

Where an insurance company sought a declaratory judgment regarding coverage under a motor vehicle policy and the jury declared that the facts did not support an allegation of arson and that coverage existed under the insurance policy, attorney fees were properly awarded under the statute. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 341 Ark. 181, 15 S.W.3d 328 (2000).

Dismissal with Prejudice.

Dismissal of declaratory judgment action with prejudice constituted a final adjudication on the merits adverse to insurance company and entitled insured to award of attorneys fees under this section. *Hicks v. Allstate Ins. Co.*, 304 Ark. 101, 799 S.W.2d 809 (1990).

Holder of Policy.

Although a party is an insured under a policy and entitled to policy protection, his claim for penalty and attorney's fee will be denied where he is not the holder of the policy. *State Farm Mut. Auto. Ins. Co. v. Pennington*, 215 F. Supp. 784 (E.D. Ark. 1963), aff'd, 324 F.2d 340 (8th Cir. 1963).

Where judgment adverse to insurer was entered in action brought by insurer against insured subcontractor, and others, only the subcontractor as the named insured and as holder of the policy was entitled to recover attorney fees. *Home Ins. Co. v. Arkansas Mechanical Contractors*, 531 F.2d 906 (8th Cir. 1976).

The statute allows attorney fees to be awarded only to the holder of an insurance policy and not to the loss-payee un-

der the policy. *Newcourt Fin., Inc. v. Canal Ins. Co.*, 341 Ark. 181, 15 S.W.3d 328 (2000).

Penalty.

Nothing in this section would prevent the allowance of the penalty provided in § 23-79-208 upon a counterclaim for a loss. *Home Ins. Co. v. Crawford*, 251 Ark. 843, 475 S.W.2d 889 (1972).

Reasonable Fees.

Attorney's fee held not unreasonable. *Aetna Cas. & Sur. Co. v. Stover*, 327 F.2d 288 (8th Cir. 1964).

Considering, from the record, the nature of the cause, novelty of questions

presented, heat of the contest, time necessary for preparation, standing and ability of attorneys on both sides, and the knowledge of the trial court of the nature and extent of services rendered, attorney fee held not excessive. *Old Republic Ins. Co. v. Alexander*, 245 Ark. 1029, 436 S.W.2d 829 (1969).

Cited: *State Farm Mut. Auto. Ins. Co. v. Pennington*, 324 F.2d 340 (8th Cir. 1963); *Smith v. Beall*, 248 Ark. 248, 451 S.W.2d 195 (1970); *Southern Farm Bureau Cas. Ins. Co. v. Gooding*, 263 Ark. 435, 565 S.W.2d 421 (1978); *Farmers Ins. Co. v. Shuffield*, 284 Ark. 158, 680 S.W.2d 96 (1984).

23-79-210. Direct cause of action against liability insurer when insured not subject to tort suit.

(a)(1) When liability insurance is carried by any cooperative non-profit corporation, association, or organization, or by any municipality, agency, or subdivision of a municipality, or of the state, or by any improvement district or school district, or by any other organization or association of any kind or character and not subject to suit for tort, and if any person, firm, or corporation suffers injury or damage to person or property on account of the negligence or wrongful conduct of the organization, association, municipality, or subdivision, its servants, agents, or employees acting within the scope of their employment or agency, then the person, firm, or corporation so injured or damaged shall have a direct cause of action against the insurer with which the liability insurance is carried to the extent of the amounts provided for in the insurance policy as would ordinarily be paid under the terms of the policy.

(2) The insurer shall be directly liable to the injured person, firm, or corporation for damages to the extent of the coverage in the liability insurance policy, and the plaintiff may proceed directly against the insurer regardless of the fact that the actual tortfeasor may not be sued under the laws of the state.

(b) Any of the organizations or entities not subject to suit for tort described in subsection (a) of this section and the officers of those organizations or entities upon the request of any person so injured or damaged shall disclose the existence of any liability insurance, the name of the insurer, and the terms, amounts, and limits provided by the policy or policies.

(c)(1) Nothing in this section shall be deemed to require the organization or entity not subject to suit for tort to carry liability insurance. This section provides only for a direct action against the insurer by the injured or damaged person in the event liability insurance is so carried.

(2) The substance of this section shall by operation of law be a part of any liability insurance policy so carried, notwithstanding the terms

of the policy itself, and any limitation in any policy restricting the right to recover to a judgment's first being obtained against a tortfeasor shall be void.

History. Acts 1959, No. 148, §§ 307-309; A.S.A. 1947, §§ 66-3240 — 66-3242.

RESEARCH REFERENCES

Ark. L. Rev. State Immunity and the Arkansas Claims Commission, 21 Ark. L. Rev. 180.

Direct Tort Liability of Insurance Carriers, 22 Ark. L. Rev. 167.

Conflict of Laws — Constitutional Law — Quasi in Rem Jurisdiction Based on Attachment of Out-of-State Defendant's Liability Insurance Policy, 23 Ark. L. Rev. 646.

Hall v. University of Nevada: Sovereign Immunity and the Transitory Action, 27 Ark. L. Rev. 546.

Leflar, Conflict of Laws: Arkansas, 1983-1987, 41 Ark. L. Rev. 63.

UALR L.J. Survey — Insurance, 10 UALR L.J. 217.

Survey, Civil Procedure, 14 UALR L.J. 285.

CASE NOTES

ANALYSIS

In general.
Construction.
Purpose.
Applicability.
Bad faith.
Bankruptcy.
Direct actions.
Employees of organizations.
Evidence.
Immunity from tort action.
Private policies.
Purchase of insurance.
Rights of parties.
Servants, agents, or employees.
Statute of limitations.

In General.

This section gives the injured parties in cases where defendants are not liable in tort or contract a direct cause of action against any insurance company that has issued a liability policy applying to the situation. Helton v. Sisters of Mercy of St. Joseph's Hosp., 234 Ark. 76, 351 S.W.2d 129 (1961).

This section does not require that the nonprofit corporation itself be the named insured under the policy; this section only mandates that the coverage be carried by the nonprofit corporation. Rogers v. Tudor Ins. Co., 325 Ark. 226, 925 S.W.2d 395 (1996).

Construction.

Direct action statutes are remedial in

nature and are liberally construed for the benefit of injured parties and to effectuate the intended purposes. Rogers v. Tudor Ins. Co., 325 Ark. 226, 925 S.W.2d 395 (1996).

The General Assembly, in enacting this section, did not equate a corporation "carrying" liability insurance on its officers and directors with "covering" the corporation itself; to interpret this section that way would be too narrow an interpretation. Rogers v. Tudor Ins. Co., 325 Ark. 226, 925 S.W.2d 395 (1996).

Purpose.

The purpose of former section was to apply only to insurance companies issuing policies to enumerated immune organizations. The purpose was clear and that purpose would not be served by extending the statute to allow a direct action against the insurer of an individual. Savage v. Spicer, 235 Ark. 946, 362 S.W.2d 668 (1962) (decision under prior law).

Applicability.

This section applies in action against insurer of Oklahoma municipality for damages sustained by Arkansas resident when his vehicle was struck by truck of municipality on highway in Arkansas as insurance company agreed in policy to be amenable to such law where municipality was engaged in activities relating to its policy coverage. Bradshaw v. St. Paul Fire

& Marine Ins. Co., 587 F. Supp. 506 (W.D. Ark. 1984).

This section, also known as the direct action statute, only allows suits against insurers for the negligence of their insureds when the insurer is a charitable organization or governmental entity. *Jarboe v. Shelter Ins. Co.*, 317 Ark. 395, 877 S.W.2d 930 (1994); *National Bank of Commerce v. Quirk*, 323 Ark. 769, 918 S.W.2d 138 (1996).

Dismissal of malpractice insurance carrier for individual defendant doctors was appropriate where plaintiffs, in their complaint, did not allege insurer was brought in as the insurer for medical center, or that the medical center was negligent. *National Bank of Commerce v. Quirk*, 323 Ark. 769, 918 S.W.2d 138 (1996).

Under this section, the following elements must exist for it to apply: (1) liability insurance must be carried by a non-profit corporation; (2) a person must suffer injury or damage on account of negligence or wrongful conduct; and (3) the damage or injury must be on account of the negligence or wrongful conduct of "servants, agents, or employees" of the nonprofit corporation acting within the scope of their agency or employment. *Rogers v. Tudor Ins. Co.*, 325 Ark. 226, 925 S.W.2d 395 (1996).

Parents of child patient who died after receiving emergency treatment brought direct action against insurer of non-profit hospital, as permitted by this section. *Kenning v. St. Paul Fire & Marine Ins. Co.*, 990 F. Supp. 1104 (W.D. Ark. 1997).

Bad Faith.

The elements for a claim for bad faith were properly pled: affirmative misconduct by the insurance company, in bad faith, and malicious or oppressive attempt to avoid liability under the policy. *Bethel Baptist Church v. Church Mut. Ins. Co.*, 54 Ark. App. 262, 924 S.W.2d 494 (1996).

Bankruptcy.

Section 23-89-102 provides that an insurer's liability is not affected by the insured's insolvency; the filing of a petition in bankruptcy is not the type of immunity contemplated by this section. *Jarboe v. Shelter Ins. Co.*, 317 Ark. 395, 877 S.W.2d 930 (1994).

Direct Actions.

Where a party injured in an automobile accident sought a judgment declaring in-

surance coverage of the tortfeasor, the action was not a direct action against the insurance company, and the circuit court was not prohibited from hearing the complaint by this section or § 23-89-101. *National Sec. Fire & Cas. Co. v. Poskey*, 309 Ark. 206, 828 S.W.2d 836 (1992).

The direct action statute does not allow injured parties to sue their nonimmune tortfeasors' insurance carriers directly until the injured party has obtained a judgment against the tortfeasor, and the judgment remains uncollected after 30 days. *National Sec. Fire & Cas. Co. v. Poskey*, 309 Ark. 206, 828 S.W.2d 836 (1992).

Employees of Organizations.

Employee of county library who was injured while distributing and collecting books transported by bookmobile properly filed direct action against liability insurer claiming that her injuries had been caused by the negligence of the library in permitting an unsafe vehicle (bookmobile) to be operated on the highways and in permitting it to be driven by an incompetent driver. *Aetna Cas. & Sur. Co. v. Brashears*, 226 Ark. 1017, 297 S.W.2d 662 (1956) (decision under prior law).

Clause in insurance policy excluding employees of charitable organization from coverage under this section was permissible. *Ramsey v. American Auto. Ins. Co.*, 234 Ark. 1031, 356 S.W.2d 236 (1962).

The fact that defendant school bus driver might be personally responsible for injuries resulting from his negligence was in no way a defense for the school district's insurer, if the driver was acting within the scope of his employment and his negligence was the proximate cause of the injuries and damages alleged to have been suffered by plaintiffs. *Hagen v. Payne*, 222 F. Supp. 548 (W.D. Ark. 1963).

Although defendants are immune from tort liability as state employees, it is a qualified immunity, and suit can be maintained against an employee to the extent the employee is protected by insurance. *Carter v. Bush*, 296 Ark. 261, 753 S.W.2d 534 (1988).

Evidence.

Proof that negligence of insured was proximate cause of damages required. *Ferrell v. Southern Farm Bureau Cas. Ins. Co.*, 291 Ark. 322, 724 S.W.2d 465 (1987).

Immunity from Tort Action.

An insurance company which acted as

liability carrier for a sheriff was not liable under this section, since this section does not extend to individuals who may be immune from suit for tort. *Hamilton v. Covington*, 445 F. Supp. 195 (W.D. Ark. 1978).

Defendant held not to qualify as an "association of any kind or character, not subject to suit for tort" under this section. *Lacey v. Bekaert Steel Wire Corp.*, 619 F. Supp. 1234 (W.D. Ark. 1985), *aff'd*, 799 F.2d 434 (8th Cir. 1986).

This section does not preempt an action in tort for bad faith misconduct. *Sparks v. Shelter Life Ins. Co.*, 838 F.2d 987 (8th Cir. 1988).

Where state fair booklet and entry forms clearly stated that the fair association would not be responsible for loss or damage to property while it was on the fair grounds and the fair booklet also specifically informed entrants that if they desired to protect their property from fire loss, they should obtain insurance against that risk, a jury could conclude that, taken as a whole, the clauses exempted the fair association from liability for negligently caused fire damage to property. *Frenslley v. National Fire Ins. Co.*, 856 F.2d 1199 (8th Cir. 1988).

As nonprofit blood bank did not cause injury to person who died from AIDS as a result of a contaminated blood transfusion through any negligence on its part, the blood bank's insurance company was not liable to the deceased person's wife on its policy of insurance under this section. *Kirkendall v. Harbor Ins. Co.*, 698 F. Supp. 768 (W.D. Ark. 1988), *aff'd*, 887 F.2d 857 (8th Cir. 1989).

Direct action against carriers is limited to the insurance carriers of cooperative nonprofit organizations, municipalities, agencies, or subdivisions of municipalities or of the state, improvement districts, school districts, or other organization of any kind or character not subject to suit in tort, and this section makes no mention of individuals. *Carter v. Bush*, 296 Ark. 261, 753 S.W.2d 534 (1988).

Statute was inapplicable where mother's negligence action against insurer of nonprofit corporation failed to allege in the pleadings that the insured was a charitable organization that was immune from suit in tort; courts have never held that charitable organizations were completely immune from suit, rather, they were only

immune from execution against their property. *Clayborn v. Bankers Std. Ins. Co.*, 348 Ark. 557, 75 S.W.3d 174 (2002).

Private Policies.

An insurer would not be liable under an insurance policy carried by private individuals, as it would not come under former section. *Savage v. Spicer*, 235 Ark. 946, 362 S.W.2d 668 (1962) (decision under prior law).

This section only permits direct action against insurance carriers issuing policies to enumerated immune organizations; so where the property owner purchased liability insurance pursuant to its municipal financing agreement, but the city was not a named insured under the policy, the direct action claim against the insurer was properly dismissed. *Lacey v. Bekaert Steel Wire Corp.*, 799 F.2d 434 (8th Cir. 1986).

Purchase of Insurance.

Because a port authority is authorized by law to purchase liability insurance under this section, an assertion that an illegal exaction under Ark. Const. Art. 16, § 13 would result from paying the insurance premium is erroneous. *Little Rock Port Auth. v. McCain*, 296 Ark. 130, 752 S.W.2d 44 (1988).

Construction company was not an insurer for the purposes of administrator's wrongful death action, notwithstanding that it agreed to indemnify the city against damages and obtained insurance to do so. *Cherry v. Tanda, Inc.*, 327 Ark. 600, 940 S.W.2d 457 (1997).

Rights of Parties.

This section can vest no greater substantive right on a third party than that capable of being asserted by the principal obligee. *Tri-State Ins. Co. v. United States*, 340 F.2d 542 (8th Cir. 1965).

Servants, Agents, or Employees.

The officers and directors of the corporation were fell within the broad category of "servants, agents, or employees" of the nonprofit corporation under this section. *Rogers v. Tudor Ins. Co.*, 325 Ark. 226, 925 S.W.2d 395 (1996).

Statute of Limitations.

While this section allows for a direct action against an insurance company, there is no indication that such an action is not subject to the statute of limitations.

Harvill v. Community Methodist Hosp. Ass'n, 302 Ark. 39, 786 S.W.2d 577 (1990).

Cited: Sams v. Pacific Indem. Co., 170 F. Supp. 909 (W.D. Ark. 1959); Martin v. Aetna Cas. & Sur. Co., 239 Ark. 95, 387 S.W.2d 334 (1965); Swan v. Estate of Monette ex rel. Monette, 265 F. Supp. 362 (W.D. Ark. 1967); Matthews v. Travelers Indem. Ins. Co., 245 Ark. 247, 432 S.W.2d 485 (1968); Gregson v. Great Am. Ins. Co., 248 Ark. 673, 453 S.W.2d 28 (1970); Lassiter v. State Farm Mut. Auto. Ins. Co., 371 F. Supp. 1221 (E.D. Ark. 1974); Carr v. St. Paul Fire & Marine Ins. Co., 384 F. Supp. 821 (W.D. Ark. 1974); Ferrara ex rel. Dagley v. Aetna Cas. & Sur., 436 F. Supp. 929 (W.D. Ark. 1977); White v. Mitchell, 263 Ark. 787, 568 S.W.2d 216 (1978); Myers v. Northwestern Nat'l Ins. Co., 534 F. Supp. 117 (W.D. Ark. 1981); Commercial Union Ins. Co. v. Sanders, 272 Ark. 25, 611 S.W.2d 754 (1981); Shafer

v. American Employers' Ins. Co., 535 F. Supp. 1067 (W.D. Ark. 1982); Mandel v. United States, 545 F. Supp. 907 (W.D. Ark. 1982); Bankston v. Pulaski County Sch. Dist., 281 Ark. 476, 665 S.W.2d 859 (1984); Mandel v. United States, 793 F.2d 964 (8th Cir. 1986); Hall v. State Farm Fire & Cas. Co., 813 F.2d 137 (8th Cir. 1987); Kelley v. Wiggins, 291 Ark. 280, 724 S.W.2d 443 (1987); Kirkendall v. Harbor Ins. Co., 887 F.2d 857 (8th Cir. 1989); State Farm Mut. Auto. Ins. Co. v. Pharr, 305 Ark. 459, 808 S.W.2d 769 (1991); Hood ex rel. Hood v. Arkansas Sch. Bd. Ins. Coop., 35 Ark. App. 1, 811 S.W.2d 1 (1991); Waire v. Joseph, 308 Ark. 528, 825 S.W.2d 594 (1992); Primm v. United States Fid. & Guar. Ins. Corp., 324 Ark. 409, 922 S.W.2d 319 (1996); George v. Jefferson Hosp. Ass'n, 337 Ark. 206, 987 S.W.2d 710 (1999); Smith v. Rogers Group, Inc., 348 Ark. 241, 72 S.W.3d 450 (2002).

SUBCHAPTER 3 — MINIMUM STANDARDS — COMMERCIAL PROPERTY AND CASUALTY INSURANCE POLICIES

SECTION.

- 23-79-301. Purpose.
- 23-79-302. Definition.
- 23-79-303. Applicability — Exceptions.
- 23-79-304. Construction.
- 23-79-305. Violations — Order.
- 23-79-306. Requirements.
- 23-79-307. Standards.
- 23-79-308. Noncomplying provisions.
- 23-79-309. Administrative procedures — Appeals.

SECTION.

- 23-79-310. Rules and regulations.
- 23-79-311. Motor vehicle liability insurance — Extraterritorial provision.
- 23-79-312. Motor vehicle liability insurance — Prohibition regarding step-downs.

Effective Dates. Acts 1987, No. 204, § 11: Mar. 13, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 1123, § 25: Apr. 9, 1991. Emergency clause provided: "It is hereby found and determined by the General As-

sembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety all provisions of this Act other than Section 22 shall be in full force and effect from and after July 1, 1991 and Section 22 shall be in full force and effect from and after the passage and approval of this Act."

Acts 1999, No. 881, § 28: Mar. 25, 1999. Emergency clause provided: "It is hereby found and determined by the Eighty-second General Assembly of the State of Arkansas that the present funeral preneed laws, employee leasing firm laws,

and other insurance laws are inadequate to protect the public. In pertinent part, the changes to the Insurance Code needed to assure the stability of funding for the Fraud Investigation Division of the Department must be enacted in the laws of this state well before the new fiscal year beginning July 1, 1999. The changes to authorized appropriations, as well as changes to the disability (health) insurance laws on individuals to conform to the federal laws on group policies with guaranteed renewability require immediate adoption; and unless this emergency clause is adopted, this act might not be-

come effective until after the beginning of the next fiscal year. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after the date of its passage and approval. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-79-301. Purpose.

The purpose of this subchapter is to provide minimum standards for commercial lines property and casualty insurance policies or contracts. These minimum standards are designed to minimize restrictions in coverage and to assure minimum standards for these commercial policies or contracts for the protection of the public. This subchapter is not intended to impede flexibility and innovation in the development of commercial property and casualty insurance policy or contract form or content. This subchapter is not intended to conflict with the provisions concerning insurance contracts in the Arkansas Insurance Code and, in particular, the provisions of § 23-60-105. This subchapter is not intended to conflict with nor apply to insurance policies and contracts of surplus line insurers operating in this state in compliance with § 23-65-310.

History. Acts 1987, No. 204, § 1; 1999, No. 881, § 14.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148.

Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 1999 amendment added the last sentence.

23-79-302. Definition.

For purposes of this subchapter, a claims-made policy as referenced in § 23-79-306 means a policy which provides coverage if a claim for damages is first made during the policy period.

History. Acts 1987, No. 204, § 4; 1991, No. 1123, § 12.

23-79-303. Applicability — Exceptions.

This subchapter shall apply to property and casualty insurance on commercial risks in this state, except:

- (1) Reinsurance;

(2) Insurance against loss of or damage to aircraft, their hulls, accessories, and equipment or against liability arising out of the ownership, maintenance, or use of aircraft;

(3) Ocean marine or foreign trade insurance;

(4) Medical malpractice insurance;

(5) Title insurance;

(6) Surety or fidelity insurance;

(7) Credit insurance;

(8) Workers' compensation or employers' liability insurance; or

(9) Large commercial risks.

History. Acts 1987, No. 204, § 2; 1999, No. 458, § 8.

Amendments. The 1999 amendment added (9) and made related changes.

23-79-304. Construction.

This subchapter shall be deemed cumulative of prior laws. No prior law or part of a law shall be deemed to be in conflict with this subchapter unless failure to so determine would prevent giving effect to an explicit provision of this subchapter.

History. Acts 1987, No. 204, § 9.

23-79-305. Violations — Order.

(a) Whenever the Insurance Commissioner shall have reason to believe that any person has violated any provision of this subchapter, the commissioner shall issue and serve upon the person a statement of the alleged violations and a notice of hearing as provided by § 23-79-309.

(b) If, after a hearing, the commissioner determines that the person has violated a provision of this subchapter, the commissioner shall issue a written order which, in the commissioner's discretion, may do one (1) or more of the following:

(1) Revoke the certificate of authority of the insurer or the license of the rate service organization;

(2) Suspend the certificate of authority of the insurer or the license of the rate service organization; and

(3) Require the payment of a monetary penalty of not more than one thousand dollars (\$1,000) for each violation or, if the commissioner has found willful violations, a penalty of not more than ten thousand dollars (\$10,000) for each violation.

History. Acts 1987, No. 204, § 6.

23-79-306. Requirements.

The following requirements are applicable only as to claims-made policies as defined in § 23-79-302:

(1) The policy application and the initial page of each claims-made policy must include a conspicuous notice at the top indicating that the contract is a claims-made policy;

(2) The insurer must provide at no additional charge an automatic sixty-day extended reporting period upon cancellation or termination of the policy by either the insured or insurer;

(3)(A) At the expiration of the automatic sixty-day extended reporting period as required by subdivision (2) of this section, the insurer must offer an extended reporting period endorsement.

(B) Any notice of termination of a claims-made policy must include a disclosure advising the insured and his or her agent of the availability of and premium for an extended reporting period endorsement and the importance of purchasing the coverage;

(4) The premium for any extended reporting period endorsement shall be based upon the rates and rating rules in effect at the inception date of the last policy period of the claims-made policy;

(5) Form or rate/rule filings restricting the risks to be covered by an extended reporting period endorsement shall not be approved or accepted for use by the Insurance Commissioner;

(6) The limit of liability in the policy aggregate for the optional extended reporting period endorsement offered by the insurer shall be no less than the greater of the amount of coverage remaining in the expiring policy aggregate or fifty percent (50%) of the aggregate at policy inception. The insurer may offer to increase the original amount of the aggregate limit of liability applicable during the period of the extended reporting period endorsement;

(7)(A) A retroactive date may only be advanced with the written consent of the first-named insured and upon one (1) or more of the following conditions:

(i) If there is a change in insurer other than another insurer within the same insurance holding company or group;

(ii) If there is a substantial change in the insured's operations which would have been a material factor in the insurer's acceptance or declination of the risk; or

(iii) At the request of the first-named insured.

(B) Prior to advancement of the retroactive date under subdivisions (7)(A)(i)-(iii) of this section, the insured must receive a disclosure form for his or her signature which acknowledges that he or she has been advised of his or her right to purchase an extended reporting period endorsement; and

(8) The insurer must provide the following loss information to the named insured within thirty (30) days of the insured's request and within fifteen (15) days after notice of cancellation or nonrenewal is issued:

(A) Description of closed claims including the date and description of occurrence, amount of payments, if any;

(B) Description of open claims including the date and description of occurrence, amount of payment, if any, and an estimate of reserves, if any; and

(C) Information on notices of occurrence including the date and an estimate of reserves, if any.

History. Acts 1987, No. 204, § 4; 1991, No. 1123, § 13.

23-79-307. Standards.

In addition to other applicable provisions of the Arkansas Insurance Code, insurers and insurance policies subject to the provisions of this subchapter shall meet the following standards:

(1) Notice of claim given by or on behalf of the named insured to any authorized agent of the insurer with specific information to identify the insured is deemed notice of claim to the insurer;

(2) Policies may be issued for a term in excess of twelve (12) months with the premium adjustable on an annual basis if the policy contains an express provision to that effect. At least thirty (30) days' advance notice in writing of the premium to be charged on the policy anniversary date must be given to the insured and the agent of record if the insured has furnished the information necessary to calculate the premium;

(3) Forms or endorsements issued after the policy inception date not at the request of the named insured that reduce, restrict, or modify the original policy coverage must be accepted and signed by the named insured;

(4) Any policy providing an aggregate limit of liability within the schedule of limits must include a notice specifying that the policy limit is an "aggregate". The aggregate limit provision must be clearly defined within the policy;

(5)(A) Policies containing provisions that would reduce the limit of liability available for judgments or settlements by the amount of payment made for defense cost or claim expenses shall not be approved by the Insurance Commissioner unless a separate limit for defense costs equal to one hundred percent (100%) of the annual aggregate limit of liability stated in the policy for judgments or settlements is offered for defense costs or claims expenses to the insured. However, no policy covering automobile liability insurance may contain the defense within the limits concept.

(B) This subsection shall not apply to policies or contracts that the commissioner may exempt by order upon a finding that this subsection may not practically be applied or that its application is not necessary or desirable for the protection of the public;

(6)(A) When an insurer revises its rates or rules and the revision results in a premium increase equal to or greater than twenty-five percent (25%) on any renewal policy issued for a term of twelve (12) months or less, the insurer shall mail or deliver to the insured's agent not less than thirty (30) days prior to the effective date of renewal, and to the insured not less than ten (10) days prior to the effective date of renewal, notice specifically stating the insurer's intention to

increase the premium by an amount equal to or greater than twenty-five percent (25%).

(B) If the notice is not given as stated in subdivision (6)(A) of this section, the insurer is required to extend the existing policy thirty (30) days from the date the notice is mailed or delivered. The premium for the policy as extended in such circumstances shall be no more than the pro rata premium of the existing policy;

(7) Except in the case of nonpayment of premium, an insurer shall renew a policy unless a written notice of nonrenewal is mailed at least sixty (60) days prior to the expiration date of the policy or, for a policy for a term longer than one (1) year and not having a fixed expiration date, sixty (60) days prior to the anniversary date; and

(8) Policies containing an exclusion for punitive damages must include a definition of punitive damages substantially similar to the following: "Punitive damages" are damages that may be imposed to punish a wrongdoer and to deter others from similar conduct.

History. Acts 1987, No. 204, § 3; 1989, No. 797, § 1; 1991, No. 1123, §§ 14, 15; 1999, No. 458, § 9; 2001, No. 1555, §§ 13-15.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Publisher's Notes. Acts 1989, No. 797, § 2, provided in part: "This Act shall be deemed cumulative of prior laws, and no prior law shall be deemed to be in conflict with this Act unless failure to so determine would prevent giving effect to an explicit provision of this Act."

Amendments. The 1999 amendment, in (6), substituted "specifically stating the insurer's" for "of the insurer's" and added "by an amount equal to or greater than twenty-five percent (25%)" in the first sentence, and deleted the former second sentence.

The 2001 amendment redesignated former (6) as present (6)(A) and (6)(B) and made related changes; substituted "revises its rates or rules and the revision" for "has filed a revision of rates or rules which" in present (6)(A); substituted "in subdivision (6)(A) of this section" for "in this subdivision (6)" in present (6)(B); and added (7) and (8).

23-79-308. Noncomplying provisions.

Any commercial property and casualty insurance policy, contract, rider, or endorsement issued after March 13, 1987, and otherwise valid that contains any condition or provision not in compliance with the requirements of this subchapter shall be construed and applied in accordance with the provisions of this subchapter.

History. Acts 1987, No. 204, § 5.

23-79-309. Administrative procedures — Appeals.

(a) Administrative procedures exercised by the Insurance Commissioner under this subchapter shall be in accordance with §§ 23-61-303 — 23-61-306.

(b) Appeals from orders of the commissioner made under this subchapter shall be made in accordance with § 23-61-307.

History. Acts 1987, No. 204, § 7.

23-79-310. Rules and regulations.

The Insurance Commissioner may promulgate such reasonable rules and regulations as are necessary to carry out the provisions of this subchapter.

History. Acts 1987, No. 204, § 8.

23-79-311. Motor vehicle liability insurance — Extraterritorial provision.

(a)(1) Motor vehicle liability insurance applies to the amounts that the owner is legally obligated to pay as damages because of accidental bodily injury and accidental property damage arising out of the ownership or operation of a motor vehicle if the accident occurs in the United States, its possessions, or Canada.

(2) Motor vehicle liability insurance must afford limits of liability not less than those required under the financial responsibility laws of the jurisdiction of this state.

(b) If the accident occurs outside this state but in the United States, its possessions, or Canada and if the limits of liability of the financial responsibility or compulsory insurance laws of the applicable jurisdiction exceed the limits of liability of the financial responsibility laws of this state, the motor vehicle liability insurance is deemed to comply with the limits of liability of the laws of the applicable jurisdiction.

(c) For purposes of this section, “motor vehicle” is defined as provided in § 27-14-207.

History. Acts 2001, No. 309, § 1.

23-79-312. Motor vehicle liability insurance — Prohibition regarding step-downs.

No motor vehicle liability insurance policy issued or delivered in this state shall contain a provision that converts the limits for bodily injury or property damage to lower limits in the event that the insured motor vehicle is involved in an accident while it is being driven by a driver other than the insured.

History. Acts 2001, No. 1438, § 1.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

SUBCHAPTER 4 — MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS ACT

SECTION.

- 23-79-401. Title.
- 23-79-402. Applicability and scope.
- 23-79-403. Definitions.
- 23-79-404. Standards for policy provisions and authority to promulgate regulations.
- 23-79-405. Loss ratio standards.

SECTION.

- 23-79-406. Disclosure standards.
- 23-79-407. Notice of free examination.
- 23-79-408. Filing requirements for advertising.
- 23-79-409. Administrative procedures.
- 23-79-410. Penalties.

Effective Dates. Acts 1992 (1st Ex. Sess.), No. 72, § 9: Mar. 20, 1992. Emergency clause provided: "It is hereby found and determined by the General Assembly that certain provisions of the Arkansas Code concernig payment of covered services are confusing and misleading and could cause irreparable harm to citizens of Arkansas. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety the provisions of this Act shall be in full force and effect from and after its passage and approval."

Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the Eighty-third General Assembly that the term disability

insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-79-401. Title.

This subchapter shall be known and cited as the "Medicare Supplement Insurance Minimum Standards Act".

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-402. Applicability and scope.

(a) Except as otherwise specifically provided in § 23-79-405, this subchapter shall apply to:

(1) All medicare supplement policies delivered or issued for delivery in this state on or after March 20, 1992; and

(2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(b) This subchapter shall not apply to a policy of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combi-

nation thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(c) The provisions of this subchapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare-eligible persons, which policies are not marketed or held to be medicare supplement policies or benefit plans.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-403. Definitions.

As used in this subchapter:

(1) "Applicant" means:

(A) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(B) In the case of a group medicare supplement policy, the proposed certificate holder;

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy;

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer;

(4) "Commissioner" means the Insurance Commissioner;

(5) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates;

(6) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

(7) "Medicare supplement policy" means a group or individual policy of accident and health insurance, a subscriber contract of a hospital and medical service corporation or health maintenance organization other than a policy issued pursuant to a contract under section 1876 or section 1833 of the Social Security Act, or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare; and

(8) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2001, No. 1603, § 34.

Amendments. The 2001 amendment, in (7), substituted "accident and health insurance" for "disability insurance, or,"

and substituted "that is advertised" for "which is advertised."

U.S. Code. The federal "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965," re-

ferred to in this section, is codified primarily as 42 U.S.C. § 1395 et seq. Sections 1876 and 1833 of the federal Social Secu-

rity Act, referred to in this section, are codified as 42 U.S.C. §§ 1395mm and 1395l, respectively.

23-79-404. Standards for policy provisions and authority to promulgate regulations.

(a) No medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(c) The Insurance Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state, including §§ 23-66-306, 23-79-109, and 23-79-112. No requirement of the Arkansas Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this subchapter, shall apply to medicare supplement policies and certificates. The standards may cover, but not be limited to:

- (1) Terms of renewability;
- (2) Initial and subsequent conditions of eligibility;
- (3) Nonduplication of coverage;
- (4) Probationary periods;
- (5) Benefit limitations, exceptions, and reductions;
- (6) Elimination periods;
- (7) Requirements for replacement;
- (8) Recurrent conditions; and
- (9) Definitions of terms.

(d) The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(e) The commissioner may adopt, from time to time, such reasonable regulations as are necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

- (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
- (2) Establishing a uniform methodology for calculating and reporting loss ratios;
- (3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare Select policies and certificates.

(f) The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-79-405. Loss ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premiums charged. The Insurance Commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-406. Disclosure standards.

(a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Insurance Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type, and arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums, and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c)(1) The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.

(2) Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage.

(3) With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(d) The commissioner may adopt regulations for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages for all accident and health insurance policies sold to persons eligible for Medicare by reason of age, other than:

- (1) Medicare supplement policies;
- (2) Disability income policies;
- (3) Basic, catastrophic, or major medical expense policies; or
- (4) Single premium, nonrenewable policies.

(e) The commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3; 2001, No. 1603, §§ 35, 36.

substituted "accident and health" for "disability" in the introductory language of (d) and (e).

Amendments. The 2001 amendment

23-79-407. Notice of free examination.

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-408. Filing requirements for advertising.

Every issuer of medicare supplement insurance policies or certificates in this state shall provide a copy of any medicare supplement advertising intended for use in this state whether through written, radio, or television medium to the Insurance Commissioner for review and approval prior to its use in this state.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-409. Administrative procedures.

Regulations adopted pursuant to this subchapter shall be subject to the provisions of § 23-61-108 and to the provisions of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

23-79-410. Penalties.

In addition to any other applicable penalties for violations of the Arkansas Insurance Code, the Insurance Commissioner may require issuers violating any provisions of this subchapter or regulations promulgated pursuant to this subchapter to cease marketing any medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take such actions as are necessary to comply with the provisions of this subchapter, or both.

History. Acts 1992 (1st Ex. Sess.), No. 72, § 3.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

SUBCHAPTER 5 — COMPREHENSIVE HEALTH INSURANCE POOL ACT

SECTION.

- 23-79-501. Purpose.
- 23-79-502. Short title.
- 23-79-503. Definitions.
- 23-79-504. Arkansas Comprehensive Health Insurance Pool.
- 23-79-505. Plan of operation.
- 23-79-506. Powers.
- 23-79-507. Funding of pool.

SECTION.

- 23-79-508. Plan administrator.
- 23-79-509. Plan eligibility.
- 23-79-510. Outline of benefits.
- 23-79-511. Confidentiality.
- 23-79-512. Collective action.
- 23-79-513. Unfair referral to plan.
- 23-79-514. Study of pool by interim committees.

Publisher's Notes. Former subchapter 5, the Comprehensive Health Insurance Pool Act, was repealed by Acts 1997, No.

292, § 17. The former subchapter was derived from the following sources:
23-79-501. Acts 1995, No. 1339, § 1.

- 23-79-502. Acts 1995, No. 1339, § 2.
23-79-503. Acts 1995, No. 1339, §§ 3, 35; Acts 1997, No. 250, § 224.
23-79-504. Acts 1995, No. 1339, § 6.
23-79-505. Acts 1995, No. 1339, § 7.
23-79-506. Acts 1995, No. 1339, § 8.
23-79-507. Acts 1995, No. 1339, § 9.
23-79-508. Acts 1995, No. 1339, § 10.
23-79-509. Acts 1995, No. 1339, § 4.
23-79-510. Acts 1995, No. 1339, § 12.

Pursuant to § 1-2-207, the amendment of § 23-79-503 by Acts 1997, No. 250, is superseded by its repeal by Acts 1997, No. 292.

Effective Dates. Acts 1997, No. 292, § 18: July 1, 1997. Emergency clause provided: "It is hereby found and determined by the General Assembly that the federal Health Insurance Portability and Accountability [Act] of 1996 becomes effective on July 1, 1997; that it is necessary that this Act become effective at the same time as the federal act; and that unless this emergency clause is adopted this Act will not go in effect until after July 1. Therefore an emergency is hereby declared to exist and this Act being immediately necessary for the public peace, health, and safety shall become effective on July 1, 1997."

Acts 2001, No. 1246, § 5: Apr. 2, 2001. Emergency clause provided: "It is found and determine by the General Assembly of the State of Arkansas that the health of the Arkansas Comprehensive Health Insurance Pool is extremely important and the Insurance Commissioner must have the ability to act to protect the pool from any deficit when the Board of Directors fails to act. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration

of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2003, No. 1327, § 7: Apr. 14, 2003. Emergency clause provided: "It is found and determined by the General Assembly that Arkansas residents who qualify for a federal tax credit for health insurance coverage because of loss of their jobs or other reasons should have access to coverage so that they can use the credit for themselves and qualifying members of their families; that making the residents eligible for enrollment in the Comprehensive Health Insurance Pool will allow them to obtain coverage and make use of their tax credits should other coverage not be available to them; and that the federal tax credits are now available. It is further found that the Arkansas Comprehensive Health Insurance Pool sustains significant operating losses because the limited premiums it can charge cannot cover the medical costs of the population it insures; that the Trade Adjustment Assistance Act of 2002 provides grant funds for some of the losses sustained by qualifying state health insurance pools during federal fiscal years 2003 and 2004; and that necessary revisions to the Arkansas Comprehensive Health Insurance Pool Act should be made immediately so that the Pool can qualify for these grants. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-79-501. Purpose.

(a)(1) Acts 1995, No. 1339, established the Arkansas Comprehensive Health Insurance Pool as a state program that was intended to provide an alternate market for health insurance for certain uninsurable Arkansas residents, and further this subchapter is intended to provide for the successor entity that will provide the acceptable alternative

mechanism as described in the Health Insurance Portability and Accountability Act of 1996 for providing portable and accessible individual health insurance coverage for federally eligible individuals as defined in this subchapter.

(2) This subchapter further is intended to provide a health insurance coverage option for persons eligible for a federal income tax credit under section 35 of the Internal Revenue Code, as created by the Trade Adjustment Assistance Reform Act of 2002 or as subsequently amended.

(b) The General Assembly declares that it intends for this program to provide portable and accessible individual health insurance coverage for every individual who qualifies for coverage in accordance with § 23-79-509(b) as a federally eligible individual or as a qualified trade adjustment assistance eligible person but does not intend for every eligible person who qualifies for pool coverage in accordance with § 23-79-509 to be guaranteed a right to be issued a policy under this pool as a matter of entitlement.

History. Acts 1997, No. 292, § 2; 2003, No. 1327, § 1.

Amendments. The 2003 amendment added (a)(2); and, in (b), deleted “federally eligible” following “coverage for every” and inserted “as a federally eligible individual or as a qualified trade adjustment assistance eligible person” following “23-79-509(b).”

U.S. Code. The Health Insurance Por-

tability and Accountability Act of 1996, referred to in this section, is Act Aug. 21, 1996, P.L. 104-191, 110 Stat. 1936, codified throughout Titles 18, 26, 29, and 42 of the U.S. Code.

Section 35 of the Internal Revenue Code of 1986 and the Trade Adjustment Assistance Reform Act of 2002, referred to in this section, are codified as 26 U.S.C. § 35 and 19 USCS § 2101nt, respectively.

23-79-502. Short title.

This subchapter may be cited as the “Comprehensive Health Insurance Pool Act”, and is amendatory to the Arkansas Insurance Code and the provisions of the Arkansas Insurance Code which are not in conflict with this subchapter are applicable to this subchapter.

History. Acts 1997, No. 292, § 1.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-79-503. Definitions.

As used in this subchapter:

(1) “Agent” means any person who is licensed to sell health insurance in this state;

(2) “Board” means the Board of Directors of the Arkansas Comprehensive Health Insurance Pool;

(3) “Church plan” has the same meaning given that term in the Health Insurance Portability and Accountability Act of 1996;

(4) “Commissioner” means the Insurance Commissioner;

(5) “Continuation coverage” means continuation of coverage under a group health plan or other health insurance coverage for former

employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or state law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, § 23-86-114 of the Arkansas Insurance Code, or any other similar requirement in another state;

(6) "Covered person" means a person who is and continues to remain eligible for pool coverage and is covered under one (1) of the plans offered by the pool;

(7)(A) "Creditable coverage" means, with respect to a federally eligible individual or a qualified trade adjustment assistance eligible person, coverage of the individual under any of the following:

- (i) A group health plan;
- (ii) Health insurance coverage, including group health insurance coverage;
- (iii) Medicare;
- (iv) Medical assistance;
- (v) 10 U.S.C. § 1071 et seq.;
- (vi) A medical care program of the Indian Health Service or of a tribal organization;
- (vii) A state health benefits risk pool;
- (viii) A health plan offered under 5 U.S.C. § 8901 et seq.;
- (ix) A public health plan, as defined in regulations consistent with section 104 of the Health Insurance Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the Department of Health and Human Services; and
- (x) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e).

(B) "Creditable coverage" does not include:

(i) Coverage consisting solely of coverage of excepted benefits as defined in section 2791(C) of Title XXVII of the Public Health Service Act, 42 U.S.C. § 300gg-91; or

(ii)(a) Any period of coverage under subdivisions (7)(A)(i)-(x) of this section that occurred before a break of more than sixty-three (63) days during all of which the individual was not covered under subdivisions (7)(A)(i)-(x) of this section.

(b) Any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than sixty-three (63) days in any creditable coverage;

(8) "Department" means the State Insurance Department;

(9) "Excess or stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount;

(10) "Federally eligible individual" means an individual resident of Arkansas:

(A) For whom:

(i) As of the date on which the individual seeks pool coverage under § 23-79-509, the aggregate of the periods of creditable coverage is eighteen (18) or more months; and

(ii) The most recent prior creditable coverage was under group health insurance coverage offered by an insurer, a group health plan, a governmental plan, a church plan, or health insurance coverage offered in connection with any such plans;

(B) Who is not eligible for coverage under: -

(i) A group health plan;

(ii) Part A or Part B of Medicare; or

(iii) Medical assistance and does not have other health insurance coverage;

(C) With respect to whom the most recent coverage within the coverage period described in subdivision (10)(A)(i) of this section was not terminated based upon a factor related to nonpayment of premiums or fraud;

(D) If the individual has been offered the option of continuation coverage under a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision or under a similar state program, who elected such coverage; and

(E) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under such a provision or program;

(11) "Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(12) "Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(13)(A) "Health insurance" means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise and includes any excess or stop-loss coverage.

(B) "Health insurance" does not include long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(14) "Health maintenance organization" shall have the same meaning as defined in § 23-76-102;

(15) "Hospital" shall have the same meaning as defined in § 20-9-201;

(16) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market but does not include short-term, limited-duration insurance;

(17)(A) "Insurer" means any entity that provides health insurance, including excess or stop-loss health insurance, in the State of Arkansas.

(B) For the purposes of this subchapter, "insurer" includes an insurance company, medical services plans, hospital plans, hospital medical service corporations, health maintenance organizations, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(18) "Medical assistance" means the state medical assistance program provided under Title XIX of the Social Security Act or under any similar program of health care benefits in a state other than Arkansas;

(19)(A)(i) "Medically necessary" means that a service, drug, supply, or article is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided.

(ii) When specifically applied to a confinement, "medically necessary" further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient.

(B) A service, drug, supply, or article shall not be medically necessary if it:

(i) Is investigational, experimental, or for research purposes;

(ii) Is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider;

(iii) Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;

(iv) Could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or

(v) Involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration;

(20) "Medicare" means coverage under Part A and Part B of Title XVII of the Social Security Act, 42 U.S.C. § 1395 et seq.;

(21) "Physician" means a person licensed to practice medicine as duly licensed by the State of Arkansas;

(22) "Plan" means the comprehensive health insurance plan as adopted by the board or by rule;

(23) "Plan administrator" means the insurer designated under § 23-79-508 to carry out the provisions of the plan of operation;

(24) "Plan of operation" means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board pursuant to this subchapter;

(25) "Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, pharmacist, or any other person or

entity licensed in Arkansas to furnish medical care, articles, and supplies;

(26) “Qualified high risk pool” has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996;

(27) “Qualified trade adjustment assistance eligible person” means a person who is a trade adjustment assistance eligible person as defined by this section and for whom, on the date an application for the individual is received by the pool under § 23-79-509, has an aggregate of at least three (3) months of creditable coverage without a break in coverage of sixty-three (63) days or more;

(28) “Resident eligible person” means a person who:

(A) Has been legally domiciled in the State of Arkansas for a period of at least:

(i) Ninety (90) days and continues to be domiciled in Arkansas; or

(ii) Thirty (30) days, continues to be domiciled in Arkansas, and was covered under a qualified high risk pool in another state up until sixty-three (63) days or less prior to the date that the pool receives his or her application for coverage; and

(B) Is not eligible for coverage under:

(i) A group health plan;

(ii) Part A or Part B of Medicare; or

(iii) Medical assistance as defined in this section and does not have other health insurance coverage as defined in this section; and

(29) “Trade adjustment assistance eligible person” means a person who is legally domiciled in the State of Arkansas on the date of application to the pool and is eligible for the tax credit for health insurance coverage premiums under section 35 of the Internal Revenue Code of 1986.

History. Acts 1997, No. 292, § 3; 1997, No. 1000, § 24; 1999, No. 1356, § 1; 2003, No. 1327, § 2.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-74-306.

Amendments. The 1999 amendment inserted (14) and (15) and redesignated the remaining subdivisions accordingly; rewrote present (27); and made stylistic changes.

The 2003 amendment inserted “or a qualified trade adjustment assistance eligible person” in (7)(A); inserted “and includes any excess or stop-loss coverage” in (13)(A); inserted present (27) and redesignated former (27) as (28); inserted the subdivision (28)(A)(i) designation and

substituted “Ninety (90)” for “For a period of at least thirty (30)” and “or” for “and”; added (28)(A)(ii); added “and” following “section” in (28)(B)(iii); added (29); and made minor stylistic changes.

U.S. Code. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), referred to in (5), is codified throughout Titles 5, 15, 19, 20, 26, 38, and 42 of the U.S. Code.

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in (7)(A)(ix), is codified as a note under 42 U.S.C. § 300gg-92.

Title XIX of the Social Security Act, referred to in (18), is codified as 42 U.S.C. § 1396 et seq.

Section 35 of the Internal Revenue Code of 1986, referred to in (29), is codified as 26 U.S.C. § 35.

23-79-504. Arkansas Comprehensive Health Insurance Pool.

(a) There is created a nonprofit legal entity to be known as the "Arkansas Comprehensive Health Insurance Pool" as the successor entity to the nonprofit legal entity established by Acts 1995, No. 1339.

(b)(1) The pool shall operate subject to the supervision and control of the Board of Directors of the Arkansas Comprehensive Health Insurance Pool. The pool is created as a political subdivision, instrumentality, and body politic of the State of Arkansas, and, as such, is not a state agency.

(2) Except to the extent defined in this subchapter, the pool will be exempt from:

(A) All state, county, and local taxes;

(B) The Arkansas Procurement Law, § 19-11-201 et seq.;

(C) The Freedom of Information Act of 1967, § 25-19-101 et seq.;
and

(D) The Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(3) The board shall consist of the following seven (7) members to be appointed by the Insurance Commissioner:

(A) Two (2) current or former representatives of insurance companies licensed to do business in the State of Arkansas;

(B) Two (2) current or former representatives of health maintenance organizations licensed to do business in the State of Arkansas;

(C) One (1) member of a health-related profession licensed in the State of Arkansas;

(D) One (1) member from the general public who is not associated with the medical profession, a hospital, or an insurer; and

(E) One (1) member to represent a group considered to be uninsurable.

(4) In making appointments to the board, the commissioner shall strive to ensure that at least one (1) person serving on the board is at least sixty (60) years of age.

(5) All terms shall be for three (3) years.

(6) The board shall elect one (1) of its members as chair.

(7) Any vacancy in the board occurring for any reason other than the expiration of a term shall be filled for the unexpired term in the same manner as the original appointment.

(8) Members of the board may be reimbursed from moneys of the pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the board but shall not otherwise be compensated for their services.

(c) All insurers, as a condition of doing business in the State of Arkansas, shall participate in the pool by paying the assessments, submitting the reports, and providing the information required by the board or the commissioner to implement the provisions of this subchapter.

(d)(1) Neither the board nor its employees shall be liable for any obligations of the pool.

(2) No board member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this subchapter.

(3) The board may provide in its bylaws or rules for indemnification of, and legal representation for, the board members and employees.

History. Acts 1997, No. 292, § 4; 2001, No. 1246, § 1.

Amendments. The 2001 amendment inserted “current or former” in (3)(A)-(B); deleted “domestic” preceding “insurance

companies” in (3)(A); and made minor stylistic changes.

Cross References. Compensation of members of state boards, § 25-16-901 et seq.

23-79-505. Plan of operation.

(a)(1) The Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall adopt a plan of operation pursuant to this subchapter and shall submit to the Insurance Commissioner for approval the plan of operation including the Arkansas Comprehensive Health Insurance Pool’s articles, bylaws and operating rules, and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the commissioner.

(2) If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.

(b) The plan of operation shall:

(1) Establish procedures for operation of the pool;

(2) Establish procedures for selecting a plan administrator in accordance with § 23-79-508;

(3) Create a fund, under management of the board, to pay administrative claims and other expenses of the pool;

(4) Establish procedures for the handling, accounting, and auditing of assets, moneys, and claims of the pool and the plan administrator;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the plan;

(6)(A) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review.

(B) The board shall retain all written complaints regarding the plan for at least three (3) years; and

(7) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this subchapter.

History. Acts 1997, No. 292, § 5.

23-79-506. Powers.

(a) The Arkansas Comprehensive Health Insurance Pool shall have the general powers and authority granted under the laws of the State of Arkansas to health insurers and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this subchapter;

(2) Sue or be sued, including taking any legal actions necessary or proper;

(3) Take such legal action as necessary, including, but not limited to:

(A) Avoiding the payment of improper claims against the pool or the coverage provided by or through the pool;

(B) Recovering any amounts erroneously or improperly paid by the pool;

(C) Recovering any amounts paid by the pool as a result of mistake of fact or law;

(D) Recovering other amounts due the pool; or

(E) Coordinating legal action with the Insurance Commissioner to enforce the provisions of this subchapter;

(4)(A) Establish and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas, deductibles, copayments, coinsurance, and any other actuarial function appropriate to the operation of the pool.

(B) Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographical variation in claim costs and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Issue policies of insurance in accordance with the requirements of this subchapter. All policy forms shall be subject to the approval of the commissioner;

(6) Authorize the plan administrator to prepare and distribute certificate of eligibility forms and enrollment instruction forms to agents and to the general public;

(7) Provide for and employ cost-containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purposes of making the plan more cost effective;

(8) Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting directly or through the plan administrator with preferred provider organizations, health maintenance organizations, physician hospital organizations, or other limited network provider arrangements;

(9) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets;

(10) Pledge, assign, and grant a security interest in any of the assessments authorized by this subchapter or other assets of the pool in order to secure any notes or other evidences of indebtedness of the pool;

(11) Provide for reinsurance of risks incurred by the pool;

(12) Provide additional types of plans to provide optional coverages, including medicare supplement health insurance;

(13) Enter into reciprocal agreements with other comparable state plans in order to provide coverage for persons who move between states and are covered by such other states' plans; and

(14) In addition to the other powers granted by the Arkansas Insurance Code, the commissioner may, after notice and hearing in accordance with the provisions of the Arkansas Insurance Code, impose a monetary penalty upon any insurer or suspend or revoke the certificate of authority to transact insurance in the State of Arkansas of any insurer who fails to pay an assessment or otherwise file any report or furnish information required to be filed with the Board of Directors of the Arkansas Comprehensive Health Insurance Pool pursuant to the board's direction that the board believes is necessary in order for the board to perform its duties under this subchapter.

(b) All outstanding contracts executed by the Board of Directors of the State Comprehensive Health Insurance Pool created by Acts 1995, No. 1339, shall be deemed continuing obligations of the board created by this subchapter.

(c) As provided for in § 23-79-502, any health insurance benefit not provided for in this subchapter shall be deemed to be in conflict with and therefore inapplicable to the provisions of this subchapter.

History. Acts 1997, No. 292, § 6; 1999, No. 1356, § 2.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 1999 amendment inserted (a)(13) and redesignated the remaining subdivisions accordingly; added (c); and made stylistic changes.

23-79-507. Funding of pool.

(a) **PREMIUMS.**

(1)(A) The Arkansas Comprehensive Health Insurance Pool shall establish premium rates for plan coverage as provided in subdivision (a)(2) of this section.

(B) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(C) Premium rates and schedules shall be submitted to the Insurance Commissioner for approval prior to use.

(2)(A)(i) With the assistance of the commissioner, the pool shall determine a standard risk rate by considering the premium rates

charged by other insurers offering health insurance coverage to individuals in Arkansas.

(ii) The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage.

(B)(i) Rates for plan coverage shall not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas.

(ii) Subject to the limits provided in this subdivision (a)(2), subsequent rates shall be established to help provide for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this section.

(b) SOURCES OF ADDITIONAL REVENUE.

(1) In addition to the powers enumerated in § 23-79-506, the pool shall have the authority to:

(A) Assess insurers in accordance with the provisions of this section; and

(B)(i) Make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses.

(ii) Any such interim assessments may be credited as offsets against any regular assessments due following the close of the fiscal year.

(2)(A) Following the close of each fiscal year, the plan administrator shall determine the net premiums, that is, premiums less administrative expense allowances, the pool expenses of administration and operation, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(B) The deficit incurred by the pool not otherwise recouped under either subdivision (b)(9) of this section or subsection (e) of this section, or both, shall be recouped by assessments apportioned among insurers by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool.

(3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in subdivision (b)(2) of this section by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all insurers.

(4)(A) If assessments or other funds received under either subdivision (b)(9) of this section or subsection (e) of this section, or both, or any combination of the assessments and funds exceed the pool's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments.

(B) As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(5) Each insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board or the commissioner.

(6)(A)(i) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board.

(ii) The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.

(B)(i) In the event an assessment against an insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection.

(ii) The insurer receiving the abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

(7) For all assessments issued by the board, beginning January 1, 1998, only those individuals, corporations, associations, or other entities defined as an insurer in § 23-79-503 shall be subject to assessment.

(8) In the event the board fails to act within a reasonable period of time to recoup by assessment any deficit incurred by the pool, the commissioner shall have all the powers and duties of the board under this chapter with respect to assessing insurers.

(9) The General Assembly further intends that the pool be eligible for, and for the pool, its board, or other officers of state government, as appropriate, to take steps necessary to obtain federal grant funds to offset losses of the pool, including any funds made available under the Trade Adjustment Assistance Reform Act of 2002.

(c) ASSESSMENT OFFSETS.

(1)(A) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the premium tax payable by that insurer for the year in which the assessment is levied or for the four (4) years subsequent to that year.

(B) No offset shall be allowed for any penalty assessed under subdivision (d)(1) of this section.

(2) Notwithstanding any provisions of this subchapter to the contrary, no insurer may be assessed in any one (1) calendar year an amount greater than the amount that that insurer paid to the state in the previous year as premium tax on the business to which this tax applies or one-hundredth of one percent (0.01%) of the total written premiums on the business in this state, whichever is greater.

(d)(1)(A) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of the notice by the insurer.

(B) Failure to timely pay the assessment will automatically subject the insurer to a ten percent (10%) penalty, which will be due and payable within the next thirty-day period.

(C) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code.

(D) The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist that justify such a waiver.

(2)(A) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code.

(B) The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist that justify the waiver.

(e) PAYMENT FROM THE STATE INSURANCE DEPARTMENT TRUST FUND.

(1)(A) Following the close of each fiscal year, the board and the plan administrator shall determine whether the pool has incurred a deficit as calculated under subdivision (b)(2) of this section.

(B) If a deficit under subdivision (b)(2) of this section has been incurred, the State Insurance Department shall transfer from the State Insurance Department Trust Fund in equal quarterly installments during the next fiscal year for deposit into the pool a sum equal to the deficit from those funds in the State Insurance Department Trust Fund that are in excess of the amount needed to meet the requirements of the approved annual budget for the applicable fiscal year but not to exceed eight million dollars (\$8,000,000).

(2) For any fiscal year in which the board and the plan administrator determine that the pool did not incur a deficit as calculated under subdivision (b)(2) of this section, the department shall not transfer any funds to the pool from the State Insurance Department Trust Fund under subdivision (e)(1)(B) of this section during the following fiscal year.

History. Acts 1997, No. 292, § 7; 2001, No. 1246, §§ 2, 3; 2003, No. 1327, § 3; 2003, No. 1583, § 5.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-74-306.

Acts 2003, No. 1583, § 6, provided: "STUDY. The Legislative Council shall conduct a study during the 2003-2005 biennium concerning alternative methods of funding for the Comprehensive Health Insurance Pool and shall report its findings to the Joint Budget Committee on or before December 31, 2004."

Amendments. The 2001 amendment

added (b)(8); redesignated former (1) as present (c)(1)(A); and added (c)(1)(B).

The 2003 amendment by No. 1327, in (a)(B)(i), substituted "Rates" for "Initial rates" and "exceed" for "be less than"; deleted last sentence of (a)(2)(B)(ii); substituted "may" for "are to" in (b)(1)(B)(ii); in (b)(2)(A), inserted "and operation" following "administration"; in (b)(2)(B), inserted "not otherwise recouped under either subdivision (b)(9) of this section or subsection (e) of this section, or both," inserted "or other funds received ... assessments and funds" in (b)(4)(A); deleted the former first two sentences of (b)(7); and added (b)(9) and (e).

The 2003 amendment by No. 1583 added (e).

U.S. Code. The Trade Adjustment Assistance Reform Act of 2002, referred to in (b)(9), is codified as 19 USCS § 2101 nt.

23-79-508. Plan administrator.

(a) The Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall select an insurer through a competitive bidding process to administer the plan. However, the administering insurer designated by the board created by Acts 1995, No. 1339, shall serve as the plan administrator under this subchapter until the expiration of the current contract of the administering insurer. The board shall evaluate bids submitted under this section based upon criteria established by the board which shall include, but not be limited to, the following:

(1) The plan administrator's proven ability to handle large group accident and health benefit plans;

(2) The efficiency and timeliness of the plan administrator's claim processing procedures;

(3) An estimate of total charges for administering the plan;

(4) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and

(5) The financial condition and stability of the plan administrator.

(b)(1) The plan administrator shall serve for a period of three (3) years subject to removal for cause and subject to the terms, conditions, and limitations of the contract between the board and the plan administrator.

(2) The board shall advertise for and accept bids to serve as the plan administrator for the succeeding three-year periods.

(c) The plan administrator shall perform functions related to the plan as may be assigned to it, including:

(1) Determination of eligibility;

(2) Payment and processing of claims;

(3) Establishment of a premium billing procedure for collection of premiums. Billings shall be made on a periodic basis as determined by the board; and

(4) Other necessary functions to assure timely payment of benefits to covered persons under the plan, including:

(A) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made; and

(B) Evaluating the eligibility of each claim for payment under the plan.

(d)(1) The plan administrator shall submit regular reports to the board regarding the operation of the plan.

(2) Frequency, content, and form of the report shall be determined by the board.

(e)(1) The plan administrator shall pay claim expenses from the premium payments received from or on behalf of plan participants and allocated by the board for claim expenses.

(2) If the plan administrator's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide additional funds to the plan administrator for payment of claims expenses.

(f) The plan administrator shall be governed by the requirements of this subchapter and shall be compensated as provided in the contract between the board and the plan administrator.

History. Acts 1997, No. 292, § 8.

23-79-509. Plan eligibility.

(a) **GENERAL ELIGIBILITY REQUIREMENTS.** The following requirements apply to a resident eligible person or a trade adjustment assistance eligible person in order for the person to be eligible for plan coverage:

(1) Except as provided in subdivision (a)(2) of this section or subsection (b) of this section, any individual person who meets the definition of resident eligible person as defined by § 23-79-503 or a trade adjustment assistance eligible person as defined by § 23-79-503 and is either a citizen of the United States or an alien lawfully admitted for permanent residence who continues to be a resident of this state shall be eligible for plan coverage if evidence is provided of:

(A) A notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition or upon such other evidence that the Board of Directors of the Arkansas Comprehensive Health Insurance Pool deems sufficient in order to verify that the applicant is unable to obtain the coverage from an insurer due to the existence or history of a medical condition;

(B)(i) A refusal by an insurer to issue individual health insurance coverage except at a rate that the board determines is substantially in excess of the applicable plan rate.

(ii) A rejection or refusal by a group health plan or insurer offering only stop-loss or excess-of-loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection; or

(C) Evidence that the applicant was covered under a qualified high risk pool of another state, provided that the coverage terminated no more than sixty-three (63) days prior to the date the pool receives the applicant's application for coverage and the other state's qualified high risk pool did not terminate the person's coverage for fraud;

(2) A person shall not be eligible for coverage under the plan if:

(A) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it except that:

(i) A person may maintain other coverage for the period of time the person is satisfying any waiting period for a preexisting condition under a plan policy; and

(ii) A person may maintain plan coverage for the period of time the person is satisfying a waiting period for a preexisting condition under another health insurance policy intended to replace the plan policy;

(B) The person is determined to be eligible for health care benefits under Title XIX of the Social Security Act;

(C) The person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage;

(D) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the plan shall be limited to benefits incurred under the plan for the same period for which premiums had been paid and the covered person remained eligible for plan coverage;

(E) The plan has paid a total of one million dollars (\$1,000,000) in benefits on behalf of the covered person;

(F) The person is a resident of a public institution; or

(G) The person's premium is paid for or reimbursed under any government-sponsored program or by any government agency, foundation, health care facility, or health care provider except for premiums paid on behalf of:

(i) A trade adjustment assistance eligible person or a qualified trade adjustment assistance eligible person in accordance with section 35 of the Internal Revenue Code; or

(ii) An otherwise qualifying full-time employee or dependent of such an employee of a government agency, foundation, health care facility, or health care provider;

(3) The board or the plan administrator shall require verification of residency and may require any additional information, documentation, or statements under oath whenever necessary to determine plan eligibility or residency;

(4) Coverage shall cease:

(A) On the date a person is no longer a resident of the State of Arkansas;

(B) On the date a person requests coverage to end;

(C) On the death of the covered person;

(D) On the date state law requires cancellation of the policy; or

(E) At the plan's option, thirty (30) days after the plan makes any written inquiry concerning a person's eligibility or place of residence to which the person does not reply; and

(5) Except under the conditions set forth in subdivision (a)(4) of this section, the coverage of any person who ceases to meet the eligibility requirements of this section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

(b) **PERSONS ELIGIBLE FOR GUARANTEED ISSUANCE OF COVERAGE.** The following requirements apply to a federally eligible individual or a qualified trade adjustment assistance eligible person in order for such an individual to be eligible for plan coverage:

(1) Notwithstanding the requirements of subsection (a) of this section, any federally eligible individual or a qualified trade adjustment

assistance eligible person for whom a plan application and such enclosures and supporting documentation as the board may require is received by the board within sixty-three (63) days after the termination of prior creditable coverage for reasons other than nonpayment of premium or fraud that covered the applicant shall qualify to enroll in the plan under the portability provisions of this subsection;

(2) Any individual seeking plan coverage under this subsection must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the board's satisfaction that he or she meets all of the requirements to be a federally eligible individual or a qualified trade adjustment assistance eligible person and is currently and permanently residing in the State of Arkansas as of the date his or her application was received by the board;

(3) A period of creditable coverage shall not be counted, with respect to qualifying an applicant for plan coverage as an individual under this subsection, if after such a period and before the application for plan coverage was received by the board, there was at least a sixty-three-day period during all of which the individual was not covered under any creditable coverage;

(4) Any individual who the board determines qualifies for plan coverage under this subsection shall be offered his or her choice of enrolling in one (1) of the alternative portability plans that the board is authorized under this subsection to establish for those individuals;

(5)(A)(i) The board shall offer a choice of health-care coverages consistent with major medical coverage under the alternative plans authorized by this subsection to every individual qualifying for coverage under this subsection.

(ii) The coverages to be offered under the plans, the schedule of benefits, deductibles, copayments, coinsurance, exclusions, and other limitations shall be approved by the board.

(B) One (1) optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in the State of Arkansas or a standard option of coverage available under the individual health insurance laws of the State of Arkansas. The standard plan that is authorized by § 23-79-510 may be used for this purpose.

(C) The board also may offer a preferred provider option and such other options as the board determines may be appropriate for individuals who qualify for plan coverage pursuant to this subsection;

(6) Notwithstanding the requirements of § 23-79-510(f), any plan coverage that is issued to individuals who qualify for plan coverage pursuant to the portability provisions of this subsection shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage;

(7) Individuals who qualify and enroll in the plan pursuant to this subsection shall be required to pay such premium rates as the board shall establish and approve in accordance with the requirements of § 23-79-507(a);

(8) The total premium, without regard to any subsidy of premium, for individuals who qualify and enroll in the plan pursuant to this subsection shall not be greater than a similarly situated individual qualifying for pool coverage under subsection (a) of this section; and

(9) A federally eligible individual who qualifies and enrolls in the plan pursuant to this subsection must continue to satisfy all of the other eligibility requirements of this subchapter to the extent not inconsistent with the Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the plan.

(c) Any person who was issued a policy pursuant to the provisions of Acts 1995, No. 1339, shall be deemed continuously covered consistent with the terms of this subchapter and reissued a new policy in accordance with the provisions of this subchapter.

History. Acts 1997, No. 292, § 9; 1999, No. 1356, § 3; 2001, No. 1246, § 4; 2003, No. 1327, § 4.

A.C.R.C. Notes. Acts 1995, No. 1339, referred to in (c), was codified as Title 23, Chapter 79, Subchapter 5, concerning the Comprehensive Health Insurance Pool Act. Subchapter 23-79-5 was subsequently repealed by Acts 1997, No. 292, § 17.

Amendments. The 1999 amendment rewrote (a)(1); inserted present (a)(2)(B) and redesignated the remaining subdivisions accordingly; and made stylistic changes.

The 2001 amendment capitalized "Resident Eligible Person" in the subsection heading of (a); substituted "the coverage from" for "such coverage from" in (a)(1)(A); substituted "waiting period for a preexisting condition" for "preexisting condition waiting period" in (a)(2)(A)(i)-(ii); and inserted "foundation, health care facility" in (a)(2)(G).

The 2003 amendment, in (a), substituted "General Eligibility Requirements" for "Resident Eligible Person" and added "or a trade adjustment assistance eligible person"; in (a)(1), substituted "§ 23-79-503(28), or a trade adjustment assistance eligible person as defined by § 23-79-503(29)" for "§ 23-79-503(27)"; added (a)(1)(C); substituted "for premiums paid

on behalf of" for "as" in (a)(2)(G); added (a)(2)(G)(i); in (b), substituted "Persons Eligible for Guaranteed Issuance of Coverage" for "Federally Eligible Individual"; inserted "or a qualified trade adjustment assistance eligible person" in (b), (b)(1) and (b)(2); deleted "federally eligible" following "Any" in (b)(2); substituted "an individual" for "a federally eligible individual" in (b)(3); in (b)(4), deleted "federally eligible" following "Any" and substituted "those" for "these federally eligible"; in (b)(5)A(i), substituted "individual qualifying for coverage under this subsection" for "federally eligible individual"; deleted "these federally eligible" preceding "individuals" in (b)(5)(C); deleted "federally eligible" preceding "individuals" in (b)(6); substituted "Individuals" for "Federally eligible individuals" in (b)(7); and inserted present (b)(8) and redesignated former (b)(8) as present (b)(9).

U.S. Code. Title XIX of the Social Security Act, referred to in (a)(2)(B), is codified as 42 USC § 1396 et seq.

The federal Health Insurance Portability and Accountability Act, referred to in (b)(9), is codified throughout U.S.C. Titles 18, 26, 29, and 42.

Section 35 of the Internal Revenue Code of 1986, referred to in (a)(2)(G)(i), is codified as 26 U.S.C. § 35.

23-79-510. Outline of benefits.

(a)(1) Subject to the contractual policy form language adopted by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool, expenses for the following services, supplies, drugs, or articles

when prescribed by a physician and determined by the plan to be medically necessary shall be covered, subject to provisions of subsection (b) of this section:

- (A) Hospital services;
- (B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or by other licensed professionals at his or her direction;
- (C) Drugs requiring a physician's prescription;
- (D) Skilled nursing services of a licensed skilled nursing facility for not more than one hundred twenty (120) days during a policy year;
- (E) Services of a home health agency up to a maximum of two hundred seventy (270) services per year;
- (F) Use of radium or other radioactive materials;
- (G) Oxygen;
- (H) Prostheses other than dental;
- (I) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which such equipment is prescribed;
- (J) Diagnostic X rays and laboratory tests;
- (K) Oral surgery for excision of partially or completed unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
- (L) Services of a physical therapist;
- (M) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;
- (N) Services for diagnosis and treatment of mental and nervous disorders or chemical and drug dependency, provided that a covered person shall be required to make a fifty percent (50%) copayment and that the plan's payment shall not exceed four thousand dollars (\$4,000) annually; and

(O) Such additional benefits deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.

(2) EXCLUSIONS. Subject to the contractual policy form language adopted by the board, the following services, supplies, drugs, or articles whether prescribed by a physician or not shall not be covered:

- (A) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;
- (B) Care that is primarily for custodial or domiciliary purposes;
- (C) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless a private room is medically necessary;
- (D) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel that exceeds the prevailing charge in the locality or for any charge not medically necessary;

(E) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(F) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(G) Dental care except as provided in subdivision (a)(1)(K) of this section;

(H) Eyeglasses and hearing aids;

(I) Illness or injury due to acts of war;

(J) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to a covered person each policy year;

(K) Personal supplies or services provided by a hospital or nursing home or any other nonmedical or nonprescribed supply or service;

(L) Routine maternity charges for a pregnancy except when added as optional coverage with payment of additional premiums;

(M) Any expense or charge for services, articles, drugs, or supplies that are not provided in accord with generally accepted standards of current medical practice;

(N) Any expense or charge for routine physical examinations or tests;

(O) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(P) Any expense incurred for benefits provided under the laws of the United States and the State of Arkansas, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;

(Q) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;

(R) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;

(S) Any expense or charge for sterilization or sterilization reversals;

(T) Any expense or charge for weight-loss programs, exercise equipment, or treatment of obesity except when certified by a physician as morbid obesity, i.e., at least two (2) times normal body weight;

(U) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;

(V) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board-approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant;

(W) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community; and

(X) Such additional exclusions deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and medical economic factors as may be deemed appropriate and promulgate benefits, deductibles, copayments, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles, copayments, and coinsurance factors annually according to the medical component of the Consumer Price Index.

(d) NONDUPLICATION OF BENEFITS.

(1)(A) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available.

(B) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance or any other source providing benefits because of a sickness or injury and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The pool shall have a cause of action against a covered person for the recovery of the amount of benefits paid that are not covered by the pool. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subdivision (d)(2).

(e) RIGHT OF SUBROGATION — RECOVERIES.

(1)(A) Whenever the pool has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence or for which an insurance company or self-insured entity is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for damages, the pool shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from the sickness or injury.

(B) The pool shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage including coverage under a

workers' compensation act without the necessity of assignment of claim or other authorization to secure the right of recovery.

(C) To enforce its subrogation right, the pool may:

(i) Intervene or join in an action or proceeding brought by the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurance carrier or self-insured entity that may be liable; or

(ii) Institute and prosecute legal proceedings against any third party or the third party's insurance carrier or self-insured entity that may be liable for the sickness or injury in an appropriate court either in the name of the pool or in the name of the covered person or his or her personal representative including his or her guardian, conservator, estate, dependents, or survivors.

(2)(A)(i) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurance carrier or self-insured entity, the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, shall notify the pool by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim.

(ii) The pool may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection.

(B) No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the pool to the extent of its interest in the settlement or judgment and of the covered person or his or her personal representative.

(3)(A) In the event that the covered person or his or her personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the pool, in its own name or in the name of the covered person or personal representative, may commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person.

(B) The covered person shall cooperate in doing what is reasonably necessary to assist the pool in any recovery and shall not take any action that would prejudice the pool's right to recovery.

(C) The pool shall pay to the covered person or his or her personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the pool and amounts paid or to be paid as costs, attorney's fees, and reasonable expenses incurred by the pool in making the collection or enforcing the judgment.

(4)(A)(i) In the event of judgment or award in either a suit or claim against a third party, the court shall first order paid from any

judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees.

(ii) After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the pool the full amount of benefits paid on behalf of the covered person under this subchapter, provided that the court may reduce and apportion the pool's portion of the judgment proportionately to the recovery of the covered person.

(B)(i) The burden of producing sufficient evidence to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction.

(ii) The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative or contributory negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs.

(C) The pool shall pay its pro rata share of the attorney's fees based on the pool's recovery as it compares to the total judgment.

(D) Any reimbursement rights of the pool shall take priority over all other liens and charges existing under the laws of the State of Arkansas.

(5) The pool may compromise or settle and release any claim for benefits provided under this subchapter or waive any claims for benefits, in whole or in part, for the convenience of the pool or if the pool determines that collection will result in undue hardship upon the covered person.

(f) PREEXISTING CONDITIONS.

(1) Except for federally eligible individuals or qualified trade adjustment assistance eligible persons qualifying for plan coverage under § 23-79-509(b) or resident eligible persons or trade adjustment assistance eligible persons who qualify for and elect to purchase the waiver authorized in subdivision (f)(2) of this section, plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition if:

(A) The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care, or treatment; or

(B) Medical advice, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of the coverage.

(2) WAIVER. The preexisting condition exclusions as set forth in subdivision (f)(1) of this section will be waived to the extent to which the resident eligible person or trade adjustment assistance eligible person:

(A) Has satisfied similar exclusions under any prior individual health insurance coverage that was involuntarily terminated; and

(B)(i) Has applied for plan coverage not later than thirty (30) days following the involuntary termination.

(ii) For each resident eligible person or trade adjustment assistance eligible person who qualifies for and elects this waiver, there shall be added on a prorated basis to each payment of premium a surcharge of up to ten percent (10%) of the otherwise applicable annual premium for as long as that individual's coverage under the plan remains in effect or sixty (60) months, whichever is less.

(3)(A) Whenever benefits are due from the plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may recover damages from a third party or its insurance carrier or self-insured entity, the plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

(B)(i) During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurance carrier or self-insured entity, any benefits that would otherwise be payable except for the provisions of this subsection shall be paid if payment by or for the third party has not yet been made and the covered person or, if capable, that person's legal representative agrees in writing to pay back properly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury.

(ii) This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

(C) Any amounts due the plan to repay benefits may be deducted from other benefits payable by the plan after payments by or for the third party are made.

(4) Benefits due from the plan may be reduced or refused as an offset against any amount otherwise recoverable under this section.

History. Acts 1997, No. 292, § 10; 2003, No. 1327, § 5.

Amendments. The 2003 amendment inserted "or qualified trade adjustment assistance eligible persons" in (f)(1); inserted "or trade adjustment assistance eligible persons" in (f)(1), (f)(2) and

(f)(2)(B)(ii); in (f)(2)(A), added "individual" following "prior" and deleted "or group health plan" following "coverage"; deleted former (f)(2)(B) and redesignated former (f)(2)(C) as present (f)(2)(B); and made minor stylistic changes.

23-79-511. Confidentiality.

(a)(1) All steps necessary under state and federal law to protect confidentiality of applicants and covered persons shall be undertaken by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool to prevent the identification of individual records of covered persons under the plan, rejected by the plan, or who may become ineligible for further participation in the plan.

(2) Procedures shall be written by the board to assure the confidentiality records of persons covered under, rejected by, or who became ineligible for further participation in the plan when gathering and submitting data to the board or any other entity.

(b) Any information submitted to the board by hospitals or any other provider pursuant to this subchapter from which the identity of a particular individual can be determined shall be privileged and confidential and shall not be disclosed in any manner. The foregoing includes, but shall not be limited to, disclosure, inspection, or copying under the Freedom of Information Act of 1967, § 25-19-101 et seq.

History. Acts 1997, No. 292, § 11.

23-79-512. Collective action.

Neither the participation in the plan as insurers, the establishment of rates, forms, or procedures nor any other joint or collective action required by this subchapter shall be the basis of any legal action, criminal or civil liability, or penalty against the plan or any insurer.

History. Acts 1997, No. 292, § 12.

23-79-513. Unfair referral to plan.

It shall constitute an unfair trade practice for the purposes of the Trade Practices Act, § 23-66-201 et seq., for an insurer, agent, broker, or third-party administrator to refer an individual to the Arkansas Comprehensive Health Insurance Pool, or arrange for an individual to apply to the pool, for the purpose of separating that individual from group health insurance coverage provided in connection with any group health insurance coverage.

History. Acts 1997, No. 292, § 13;
1997, No. 1000, § 25.

23-79-514. Study of pool by interim committees.

The Senate Interim Committee on Insurance and Commerce and the House Interim Committee on Insurance and Commerce shall conduct a study of the Arkansas Comprehensive Health Insurance Pool for the purpose of determining alternative permanent funding sources for the deficits incurred by the pool in the future.

History. Acts 2003, No. 1327, § 6. interim committees — Members, § 10-3-203.
Cross References. Establishment of

SUBCHAPTER 6 — COVERAGE FOR DIABETES TREATMENT

SECTION.	SECTION.
23-79-601. Definitions.	viders — Prescription by
23-79-602. Diabetes self-management training — Licensed pro-	physician.
	23-79-603. Requirements.

SECTION.

23-79-604. Exclusions.

23-79-605. Regulations.

23-79-606. Applicability — Delivery
within state.

SECTION.

23-79-607. Applicability — Exceptions.

23-79-601. Definitions.

As used in this subchapter:

(1) "Diabetes self-management training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association;

(2) "Health care insurer" means any insurance company, fraternal benefit society, hospital and medical services corporation, or health maintenance organization issuing or delivering a health insurance policy subject to any of the following laws:

(A) The Arkansas Insurance Code;

(B) Section 23-74-101 et seq., relating to fraternal benefit societies;

(C) Section 23-75-101 et seq., pertaining to hospital medical service corporations;

(D) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(E) Any successor law of the foregoing; and

(3) "Health insurance policy" means a group insurance policy, contract, or plan or an individual policy, contract, or plan which provides medical coverage on an expense incurred, service, or prepaid risk-sharing basis. The term includes, but is not limited to, a policy, contract, or plan issued by an entity subject to any of the following laws:

(A) The Arkansas Insurance Code;

(B) Section 23-74-101 et seq., relating to fraternal benefit societies;

(C) Section 23-75-101 et seq., pertaining to hospital medical service corporations;

(D) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(E) Any successor law of the foregoing.

History. Acts 1997, No. 1249, § 1.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148.

Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-79-602. Diabetes self-management training — Licensed providers — Prescription by physician.

(a) Every health insurance policy shall include coverage for one (1) per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

(b) Every health care insurer shall offer, in addition to the one (1) lifetime training program provided in subsection (a) of this section, additional diabetes self-management training in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

(c) A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

(d) Diabetes self-management training shall be provided only upon prescription by a physician licensed under § 17-95-201 et seq.

(e) Nothing in this subchapter shall be construed to prohibit health care insurers from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

History. Acts 1997, No. 1249, § 2.

23-79-603. Requirements.

(a) Every health insurance policy shall include medical coverage for medically necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a physician licensed under § 17-95-201 et seq.

(b) The coverage required by this section shall be consistent with that established for other services covered by a given health insurance policy in regard to any of the following:

(1) Deductibles, coinsurance, other patient cost-sharing amounts or out-of-pocket limits; or

(2) Prior authorization or other utilization review requirements or processes.

History. Acts 1997, No. 1249, § 3.

23-79-604. Exclusions.

This subchapter shall not be construed as prohibiting a health insurance policy from excluding from coverage diabetes self-manage-

ment training or equipment or supplies and related services for the treatment of Type I, Type II, or gestational diabetes when the training, equipment, supplies, and services are not medically necessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and regulations.

History. Acts 1997, No. 1249, § 4.

23-79-605. Regulations.

The State Insurance Department shall develop and promulgate regulations to implement the provisions of this subchapter.

History. Acts 1997, No. 1249, § 5.

23-79-606. Applicability — Delivery within state.

(a) This subchapter shall apply to any health insurance policy that is delivered, issued for delivery, renewed, extended, or modified in this state on or after August 1, 1997.

(b) If a health insurance policy provides coverage or benefits to an Arkansas resident, the policy shall be deemed to be delivered in this state within the meaning of this subchapter, regardless of whether the health care insurer or other entity that provides the coverage is located within or outside of Arkansas.

History. Acts 1997, No. 1249, § 6.

23-79-607. Applicability — Exceptions.

This subchapter shall not apply to:

- (1) Long-term care plans;
- (2) Disability income plans;
- (3) Short-term nonrenewable individual health insurance policies that expire after six (6) months;
- (4) Medical payments under homeowner or automobile insurance policies; and
- (5) Workers' compensation insurance.

History. Acts 1997, No. 1249, § 7.

SUBCHAPTER 7 — TAX CREDITS FOR MEDICALLY NECESSARY FOODS

SECTION.

23-79-701. Definitions.

23-79-702. Tax credit for medically necessary medical foods and low protein modified food products.

SECTION.

23-79-703. Health insurance coverage for medically necessary foods.

Effective Dates. Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the Eighty-third General Assembly that the term disability insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the pres-

ervation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-79-701. Definitions.

As used in this subchapter:

(1) "Health care services" means any services included in the furnishing to any individual of medical or hospitalization or services incident to the furnishing of care or hospitalization, as well as the furnishing to any person of any and all other services or goods for the purpose of preventing, alleviating, curing, or healing human illness or injury;

(2) "Health plan" means any group, blanket, or individual accident and health insurance policy, contract, or plan issued in this state by an insurance company, hospital medical service corporation, or health maintenance organization, provided that nothing in this subchapter shall apply to accident only, specified disease, hospital indemnity, medicare supplement, long-term care, disability income, or other limited benefit health insurance policies;

(3) "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry;

(4) "Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease;

(5) "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician; and

(6) "Provider" means any person who is licensed in this state to furnish health care services as a health professional.

History. Acts 1999, No. 1113, § 1; 2001, No. 95, § 1; 2001, No. 1603, § 37.

Amendments. The 2001 amendment by No. 95 added the proviso in (2).

The 2001 amendment by No. 1603, in (2), substituted "accident and health" for "disability."

23-79-702. Tax credit for medically necessary medical foods and low protein modified food products.

(a) A credit of up to two thousand four hundred dollars (\$2,400) per year per child shall be allowed to individuals or to families with a dependent child or children with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism against the income tax imposed by the Income Tax Act of 1929, § 26-51-101 et seq., for expenses for the purchase of medically necessary medical foods and low protein modified food products.

(b) The credit allowed in this section shall be effective for taxable years beginning January 1, 1999.

(c) To the extent that the credit fully available under this subchapter is not fully utilized in this first year, it may be carried forward for an additional two (2) years. Any credit remaining thereafter shall expire.

History. Acts 1999, No. 1113, § 2; 2003, No. 1440, § 1. acidemias, and disorders of amino acid metabolism” and made minor stylistic changes.

Amendments. The 2003 amendment, in (a), inserted “galactosemia, organic

23-79-703. Health insurance coverage for medically necessary foods.

(a) All health plans issued, delivered, amended, or modified on or after January 1, 2000, shall provide the minimum benefits set out in subsection (b) of this section for medical foods and low protein modified food products for the treatment of a covered person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if:

(1) The medical food or low protein modified food products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;

(2) The products are administered under the direction of a physician licensed under § 17-95-401 et seq.; and

(3) The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person allowed under § 23-79-702.

(b)(1) Every health insurance policy, contract, certificate, or health care plan issued in this state by an insurance company, hospital medical service corporation, or health maintenance organization, other than coverage limited to expenses from accident only, specified disease, hospital indemnity, medicare supplement, long-term care, disability income, or other limited benefit health insurance policies, whether an individual or group policy, contract, certificate, or health care plan, that covers the insured and members of the insured's family shall provide coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas

prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

(2) This benefit may be subject to a deductible, copayments, coinsurance, or other patient cost-sharing amounts required by the health plan.

(c) If the cost of the medical food or low protein modified food products for an individual or a family with a dependent child or children exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per child allowed under § 23-79-702 and the individual or a family with a dependent child or children has been denied accident and health insurance or coverage for phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism or cannot afford insurance coverage for phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, the Department of Health shall reimburse the provider up to one thousand dollars (\$1,000) per individual from any funds appropriated therefor for the required health care service, including screening, diagnostic, and treatment services.

History. Acts 1999, No. 1113, § 3; 2001, No. 1603, § 38; 2001, No. 1654, § 1; 2003, No. 1440, § 2.

Amendments. The 2001 amendment by No. 1603 substituted “accident and health insurance” for “health or disability insurance” in (c).

The 2001 amendment by No. 1654 redesignated former (b) as present (b)(2)

and made related changes; and inserted (b)(1).

The 2003 amendment inserted “galactosemia, organic acidemias, and disorders of amino acid metabolism” in the introductory paragraph of (a), (a)(1), (b)(1), and twice in (c); and made stylistic changes in (a)(3) and (c).

SUBCHAPTER 8 — ARKANSAS HEALTH INSURANCE CONSUMER CHOICE ACT

SECTION.

23-79-801. Title.

23-79-802. Definitions.

23-79-803. Requirements relating to offering a health benefits

SECTION.

plan not subject to state-mandated health benefits.

23-79-804. [Repealed.]

23-79-805. Regulations.

23-79-801. Title.

This subchapter shall be known and cited as the “Arkansas Health Insurance Consumer Choice Act”.

History. Acts 2001, No. 924, § 1.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

23-79-802. Definitions.

As used in this subchapter:

(1) "Health benefits plan" means any individual, blanket, or group plan, policy, or contract for health care services, issued or delivered by a health care insurer, health maintenance organization, or hospital and medical service corporation, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202; and

(2)(A)(i) "State-mandated health benefits" means coverages for health care services or benefits required by state law or state regulations, requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person.

(ii) However, for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any health care services or benefits that were mandated by Acts 1971, No. 34.

(B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or regulations unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115.

History. Acts 2001, No. 924, § 2.

referred to in subdivision (2)(A), is codified

A.C.R.C. Notes. Acts 1971, No. 34, at § 23-79-114.

23-79-803. Requirements relating to offering a health benefits plan not subject to state-mandated health benefits.

(a) Every group accident and health insurer, hospital and medical service corporation, or health maintenance organization transacting health or accident and health insurance in this state may offer, as an option, a group health benefits plan that, either in whole or in part, does not provide state-mandated health benefits on group health benefits plans under state law.

(b) Every accident and health insurer transacting individual major medical insurance in this state may offer, as an option, an individual health benefits plan that, either in whole or in part, does not provide state-mandated health benefits on individual health benefit plans under state law.

(c) In each sale of health policies or health contracts in which the proposed insured has selected a health benefits plan that, either in whole or in part, does not provide state-mandated health benefits, the

accident and health insurer, hospital and medical service corporation, or health maintenance organization shall provide to the policyholder and to each certificate holder of a group health benefit plan a written notice, in a form and manner required by rule or regulation promulgated by the Insurance Commissioner, that one (1) or more of the mandated benefits are not included in the health benefit plan selected by the policyholder.

History. Acts 2001, No. 924, § 3; 2003, No. 1359, § 1.

Amendments. The 2003 amendment rewrote (c); and deleted (d) and (e).

23-79-804. [Repealed.]

Publisher's Notes. This section, concerning an annual report on the number of mandate option policies issued, was re-

pealed by Acts 2003, No. 1359, § 2. The section was derived from Acts 2001, No. 924, § 4.

23-79-805. Regulations.

The Insurance Commissioner may promulgate regulations necessary to implement the provisions of this subchapter.

History. Acts 2001, No. 924, § 5.

SUBCHAPTER 9 — ARKANSAS ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

SECTION.

- 23-79-901. Purpose.
- 23-79-902. Commission established —
Members — Meetings.
- 23-79-903. Duties of the commission.

SECTION.

- 23-79-904. Contract services — Staff assistance.
- 23-79-905. Submission of report.

Effective Dates. Acts 2001, No. 1730, § 9: Apr. 18, 2001. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that a thorough review and analysis of various mandated health insurance benefits is essential to the economic and personal well-being of the citizens of the State of Arkansas; that the establishment and continuation of a program to accomplish a review and analysis is critical for the provision of viable insurance products offered in this state; and that a delay in the effective date of this act beyond July 1, 2001, could work irreparable harm upon

the proper administration and provision of this essential government program. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-79-901. Purpose.

It is the intent of the General Assembly to encourage health care cost containment while preserving the quality of care offered to citizens of this state. The General Assembly finds that there is an increasing number of proposals that mandate that certain health insurance benefits be provided by insurers as components of individual and group accident and health policies.

History. Acts 2001, No. 1730, § 1.

23-79-902. Commission established — Members — Meetings.

(a) The Arkansas Advisory Commission on Mandated Health Insurance Benefits is established to advise the Governor and the General Assembly on the social, medical, and financial impact of current and proposed mandated benefits and providers.

(b) The commission shall be composed of fourteen (14) members as follows:

(1) Five (5) members shall be appointed by the Governor as follows:

(A) One (1) member who is a physician;

(B) One (1) member who is a representative of the State Insurance Department;

(C) One (1) member with individual health insurance; and

(D) Two (2) members of the general public;

(2) Five (5) members shall be appointed by the President Pro Tempore of the Senate as follows:

(A) One (1) member who is a representative of a general acute care hospital;

(B) One (1) member who is a representative of a major industry;

(C) One (1) member who is a representative of the accident and health insurance industry;

(D) One (1) member who is a dentist; and

(E) One (1) member who is a representative of organized labor; and

(3) Four (4) members shall be appointed by the Speaker of the House of Representatives as follows:

(A) One (1) member who is a representative of a small business;

(B) One (1) member who is a licensed accident and health insurance agent;

(C) One (1) member who is a representative of the accident and health insurance industry; and

(D) One (1) member who is a licensed chiropractor.

(c)(1) All members shall be appointed for terms of four (4) years each, except for the initial term provided for in subdivision (c)(3) of this section.

(2) Appointments to fill vacancies shall be made for the remainder of an unexpired term only.

(3) The initial terms shall be staggered and shall begin September 1, 2001, with seven (7) members serving an initial term of two (2) years

and the seven (7) remaining members serving an initial term of four (4) years. The initial terms shall be determined by lot.

(4) No person shall be eligible to serve more than two (2) successive terms, or a portion thereof. However, members may be appointed to additional successive terms after a one-year break in service.

(d) The commission shall meet quarterly or at the request of the Governor. At the first meeting, which shall be held within thirty (30) days after the appointment of the commission, the commission shall select a chair and a vice chair from its membership.

History. Acts 2001, No. 1730, §§ 2-4.

23-79-903. Duties of the commission.

The Arkansas Advisory Commission on Mandated Health Insurance Benefits shall assess the social, medical, and financial impacts of a proposed mandated health insurance service. In assessing a proposed mandated health insurance service and to the extent that information is available, the commission shall consider:

(1) Social impact, including:

(A) The extent to which the service is generally utilized by a significant portion of the population;

(B) The extent to which the insurance coverage is already generally available;

(C) If coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;

(D) If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;

(E) The level of public demand for the service;

(F) The level of public demand for insurance coverage of the service;

(G) The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and

(H) The extent to which the mandated health insurance service is covered by self-funded employer groups;

(2) Medical impacts, including:

(A) The extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;

(B) The extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and

(C) The extent to which the service is generally available and utilized by treating physicians; and

(3) Financial impacts, including:

(A) The extent to which the coverage will increase or decrease the cost of the service;

(B) The extent to which the coverage will increase the appropriate use of the service;

- (C) The extent to which the mandated service will be a substitute for a more expensive service;
- (D) The extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policyholders;
- (E) The impact of this coverage on the total cost of health care; and
- (F) The impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

History. Acts 2001, No. 1730, § 5.

23-79-904. Contract services — Staff assistance.

- (a) The Arkansas Advisory Commission on Mandated Health Insurance Benefits may contract for actuarial services and other professional services as needed.
- (b) The State Insurance Department and other state agencies, as may be considered appropriate by the commission, shall provide staff assistance to the commission.

History. Acts 2001, No. 1730, §§ 6, 7.

23-79-905. Submission of report.

Each December 31 immediately preceding a regular session of the General Assembly, the Arkansas Advisory Commission on Mandated Health Insurance Benefits shall submit a report on its findings, including any recommendations, to the Governor and the General Assembly.

History. Acts 2001, No. 1730, § 8.

A.C.R.C. Notes. As originally codified,

this section began “On or before December 31, 2002, and.”

SUBCHAPTER 10 — HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY INITIATIVE

SECTION.	SECTION.
23-79-1001. Findings and purpose.	23-79-1004. Arkansas Safety-net Benefit Fund.
23-79-1002. Medicaid demonstration initiative.	23-79-1005. Department of Human Services — Powers and duties.
23-79-1003. Arkansas Safety-net Benefit Program.	

Cross References. Joint Interim Committee on Health Insurance and Prescription Drugs study, § 10-3-2003.

23-79-1001. Findings and purpose.

(a) The General Assembly finds that:

(1) Many Arkansans have no health insurance;

(2) Increasing the number of persons with health insurance will improve the overall health of the people of the state; and

(3) The United States Department of Health and Human Services created the Health Insurance Flexibility and Accountability demonstration initiative to give states more flexibility in creating approaches to maximize private health care options.

(b) The Arkansas Safety-net Benefit Program is intended to provide safety-net health care for qualifying uninsured employed individuals.

History. Acts 2003, No. 1044, § 1.

23-79-1002. Medicaid demonstration initiative.

(a) Subject to obtaining all necessary federal approvals, including approval of a demonstration waiver under section 1115 of the Social Security Act as in effect January 1, 2003, the Department of Human Services may administer the Health Insurance Flexibility and Accountability demonstration initiative created in § 23-79-1004.

(b) Coverage may include certain spouses of covered employed individuals.

History. Acts 2003, No. 1044, § 1.

U.S. Code. Section 1115 of the Social

Security Act, referred to in (a), is codified as 42 U.S.C. § 1315.

23-79-1003. Arkansas Safety-net Benefit Program.

(a)(1) There is created the Arkansas Safety-net Benefit Program.

(2) Employer participation in the program shall be voluntary.

(b) Employers electing to participate shall comply with all program requirements, including, but not limited to:

(1) Establishing that all employees have health insurance coverage; and

(2) Making payments to the program at times and in amounts as determined by the Department of Human Services to be necessary for the operation of the program for:

(A) All covered employees and covered spouses; and

(B) All other employees, regardless of income, except employees exempted by rule of the department.

History. Acts 2003, No. 1044, § 1.

23-79-1004. Arkansas Safety-net Benefit Fund.

(a)(1) There is created the Arkansas Safety-net Benefit Fund.

(2) The fund shall be administered by the Department of Finance and Administration and shall consist entirely of revenues derived from employer payments to the Arkansas Safety-net Benefit Program.

(b)(1) The fund shall not be deposited in a general revenue holding account or be regulated by the State Insurance Department and shall be used only for the program.

(2) However, if the federal government eliminates or substantially modifies the Health Insurance Flexibility and Accountability demonstration initiative or withdraws approval of the Arkansas Safety-Net Benefit Program, moneys remaining in the fund shall not be placed in the State Treasury but shall be expended to provide services to beneficiaries of the program.

(3) Moneys in the fund may carry over from the first fiscal year of any biennium to the second fiscal year of the biennium and from one biennium to the next.

History. Acts 2003, No. 1044, § 1.

23-79-1005. Department of Human Services — Powers and duties.

(a) The Department of Human Services shall promulgate rules to implement this subchapter.

(b) The department shall administer the Arkansas Safety-net Benefit Program and the Arkansas Safety-net Benefit Fund.

(c) The department shall:

(1) Prepare and submit to the United States Department of Health and Human Services a request for a demonstration waiver under section 1115 of the Social Security Act, describing one (1) or more statewide health insurance limited safety-net benefit packages that can be funded within existing allotments received by the state under Title XXI of the Social Security Act;

(2) Administer the Arkansas Safety-net Benefit Program and the Arkansas Safety-net Benefit Fund in accordance with a federally approved Health Insurance Flexibility and Accountability demonstration initiative waiver;

(3) Deposit Arkansas Employer Sponsored Insurance Fund revenues in insured interest-bearing accounts at banking institutions in Arkansas; and

(4) Expend Arkansas Safety-net Benefit Fund moneys as state matching funds in accordance with the requirements of federal health care programs and the Arkansas Safety-net Benefit Program.

History. Acts 2003, No. 1044, § 1.

(c)(1), are codified as 42 U.S.C. § 1315 and

U.S. Code. Section 1115 and Title XXI of the Social Security Act, referred to in

42 U.S.C. § 1397aa et seq., respectively.

CHAPTER 80

INSURANCE POLICIES — SIMPLIFICATION

SUBCHAPTER.

1. GENERAL PROVISIONS. [RESERVED.]

2. LIFE AND ACCIDENT AND HEALTH INSURANCE POLICY LANGUAGE SIMPLIFICATION ACT.

SUBCHAPTER.

3. PROPERTY AND CASUALTY INSURANCE POLICY SIMPLIFICATION ACT.
4. PRESCRIPTION DRUG PAPERWORK SIMPLIFICATION.

SUBCHAPTER 1 — GENERAL PROVISIONS

[Reserved]

SUBCHAPTER 2 — LIFE AND ACCIDENT AND HEALTH INSURANCE POLICY
LANGUAGE SIMPLIFICATION ACT

SECTION.

- 23-80-201. Title.
23-80-202. Purpose.
23-80-203. Definitions.
23-80-204. Applicability.
23-80-205. Construction.

SECTION.

- 23-80-206. Minimum standards.
23-80-207. Authorization to use lower
score.
23-80-208. Approval of forms.

Publisher's Notes. Acts 1979, No. 258, § 9, provided, in part, that except as provided in § 23-80-204 the act applied to all policy forms filed on or after two years after the act's effective date. The section further provided that no policy form would be delivered or issued for delivery in the state on or after five years after the effective date of the act unless approved by the Insurance Commissioner or permitted to be issued under the act. Additionally the section provided that any form which had been approved or permitted to be issued prior to five years after the act's effective date and which met the standard set by the act need not be refiled for approval, but would continue to be lawfully delivered or issued for delivery upon filing with the commissioner a list of the forms identified by form number accompanied by a certificate as provided for in § 23-80-206(d). The section further provided that the commissioner could, in his discretion, extend the above dates.

Effective Dates. Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the Eighty-third General Assembly that the term disability insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-80-201. Title.

This subchapter may be cited as the "Life and Accident and Health Insurance Policy Language Simplification Act".

History. Acts 1979, No. 258, § 1; A.S.A. 1947, § 66-3251; Acts 2001, No. 1603, § 39.

Amendments. The 2001 amendment substituted "Accident and Health" for "Disability" in the introductory language.

23-80-202. Purpose.

(a) The purpose of this subchapter is to establish minimum standards for language used in policies, contracts, and certificates of life insurance and annuities, accident and health insurance, credit life insurance, and credit disability insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.

(b)(1) This subchapter is not intended to increase the risk assumed by insurance companies or other entities subject to this subchapter or to supersede their obligation to comply with the substance of other insurance legislation applicable to life, accident and health, credit life, or credit disability insurance policies or annuities.

(2) This subchapter is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

History. Acts 1979, No. 258, § 2; A.S.A. 1947, § 66-3252; Acts 2001, No. 1603, § 40.

Amendments. The 2001 amendment substituted “accident and health” for “disability” in (a) and (b)(1).

23-80-203. Definitions.

As used in this subchapter:

(1) “Commissioner” means the Insurance Commissioner;

(2) “Company” or “insurer” means any life or accident and health insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations; and

(3) “Policy” or “policy form” means any:

(A) Policy, contract, plan, or agreement of life insurance and annuities or accident and health insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in this state by any company subject to this subchapter;

(B) Certificate, contract, or policy issued by a fraternal benefit society;

(C) Certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and

(D) Evidence of coverage issued by a health maintenance organization.

History. Acts 1979, No. 258, § 3; A.S.A. 1947, § 66-3253; Acts 2001, No. 1603, § 41.

Amendments. The 2001 amendment

substituted “accident and health” for “disability” in (2) and (3)(A); and added the subdivisions designations in (3) and made related changes.

23-80-204. Applicability.

(a) This subchapter shall apply to all policies delivered or issued for delivery in this state by any company on or after the date the forms must be approved under this subchapter.

(b) However, nothing in this subchapter shall apply to:

(1) Any policy which is a security subject to federal jurisdiction;

(2)(A) Any group policy covering a group of one thousand (1,000) or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy.

(B) However, this subdivision (b)(2) shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state;

(3) Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;

(4) Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates the forms must be approved under this subchapter; or

(5) The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under this subchapter.

(c) No other statute of this state setting language simplification standards shall apply to any policy forms.

(d) Any non-English language policy delivered or issued for delivery in this state shall be deemed to be in compliance with § 23-80-206(a)(1) if the insurer certifies that the policy is translated from an English language policy which does comply with § 23-80-206(a)(1).

History. Acts 1979, No. 258, § 4;
A.S.A. 1947, § 66-3254.

23-80-205. Construction.

Nothing in this subchapter shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.

History. Acts 1979, No. 258, § 6;
A.S.A. 1947, § 66-3256.

23-80-206. Minimum standards.

(a) In addition to any other requirements of law, no policy forms, except as stated in § 23-80-204, shall be delivered or issued for delivery in this state on or after the dates forms must be approved under this subchapter, unless:

(1) The text achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (c) of this section;

(2) It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one-point leaded;

(3) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

(4) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand (3,000) words printed on three (3) or fewer pages of text, or if the policy has more than three (3) pages, regardless of the number of words.

(b)(1) For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:

(A) For policy forms containing ten thousand (10,000) words or less, the entire form shall be analyzed. For policy forms containing more than ten thousand (10,000) words, the readability of two (2) two-hundred-word samples per page may be analyzed instead of the entire form. The samples shall each be separated by at least ten (10) printed lines;

(B) The number of words and sentences in the text shall be counted, and then the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015;

(C) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6; and

(D) The sum of the figures computed under subdivisions (b)(1)(B) and (C) of this section subtracted from 206.835 equals the Flesch reading ease score for the policy form.

(2) For purposes of subdivisions (b)(1)(B)-(D) of this section, the following procedures shall be used:

(A) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one (1) word;

(B) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(C)(i) A syllable means a unit of spoken language consisting of one (1) or more letters or a word as divided by an accepted dictionary.

(ii) When the dictionary shows two (2) or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(3) The term "text" as used in this section shall include all printed matter except the following:

(A) The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, and specification pages, schedules, or tables; and

(B) Any policy language which is drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words which are defined in the policy, and any policy language required by law or regulation, provided that

the insurer identifies the language or terminology excepted by this subdivision (b)(3) and certifies in writing that the language or terminology is entitled to be excepted by this subdivision (b)(3).

(c) Any other reading test may be approved by the Insurance Commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(d)(1) Filings subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with § 23-80-207.

(2) To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

(e) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

History. Acts 1979, No. 258, § 5;
A.S.A. 1947, § 66-3255.

23-80-207. Authorization to use lower score.

The Insurance Commissioner may authorize a lower score than the Flesch reading ease score required in § 23-80-206(a)(1) whenever, in the commissioner's discretion, he or she finds that a lower score:

(1) Will provide a more accurate reflection of the readability of a policy form;

(2) Is warranted by the nature of a particular policy form or type or class of policy forms; or

(3) Is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation, or agency interpretation.

History. Acts 1979, No. 258, § 7;
A.S.A. 1947, § 66-3257.

23-80-208. Approval of forms.

A policy form meeting the requirements of § 23-80-206(a) shall be approved notwithstanding the provisions of any other laws which specify the content of policies if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

History. Acts 1979, No. 258, § 8;
A.S.A. 1947, § 66-3258.

SUBCHAPTER 3 — PROPERTY AND CASUALTY INSURANCE POLICY SIMPLIFICATION ACT

SECTION.

23-80-301. Title.

23-80-302. Purpose.

23-80-303. Definitions.

23-80-304. Applicability.

23-80-305. Powers of the commissioner.

SECTION.

23-80-306. Minimum standards.

23-80-307. Compliance with other statutorily required language.

23-80-308. Compliance by provision of outline of coverage.

Effective Dates. Acts 2001, No. 1603, § 66: Apr. 13, 2001. Emergency clause provided: "It is found and determined by the Eighty-third General Assembly that the term disability insurance is obsolete in the insurance industry and should be updated to the usage of accident and health insurance to conform with national industry standards. Therefore, an emergency is declared to exist and this act being immediately necessary for the pres-

ervation of the public peace, health and safety shall become effective on the date of its approval by the governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

23-80-301. Title.

This subchapter may be cited as the "Property and Casualty Insurance Policy Simplification Act".

History. Acts 1981, No. 517, § 1;
A.S.A. 1947, § 66-5801.

23-80-302. Purpose.

(a) The purpose of this subchapter is to establish minimum language and format standards to make property and casualty insurance policies easier to read.

(b) This subchapter is not intended to increase the risk assumed under policies subject to it. Nor is it intended to impede flexibility and innovation in the development of policy forms or content. It does not grant authority to the Insurance Commissioner to mandate the standardization of policy forms or content.

History. Acts 1981, No. 517, § 2;
A.S.A. 1947, § 66-5802.

23-80-303. Definitions.

As used in this subchapter:

(1) "Casualty insurance" does not include accident and health insurance;

(2) "Commissioner" means the Insurance Commissioner; and

(3) “Policy” or “policy forms” means any written contract of property and casualty insurance delivered or issued for delivery in this state by or on behalf of any insurer licensed in this state.

History. Acts 1981, No. 517, § 3; A.S.A. 1947, § 66-5803; Acts 2001, No. 1603, § 42.

Amendments. The 2001 amendment deleted “or disability insurance” at the end of (1).

23-80-304. Applicability.

(a) This subchapter shall apply to all policies with effective dates on or after the implementation date established for policies under § 23-80-306(b).

(b) No other statute of this state setting simplification standards for language or format shall apply to any policy.

(c) This subchapter shall not apply to policies in manuscript form or to the following kinds of insurance:

- (1) Ocean marine;
- (2) Surety and financial institution bonds;
- (3) Reinsurance; or
- (4) Commercial aviation.

(d) Any non-English language policy shall be deemed in compliance with § 23-80-306(a) if it was translated from an English language policy which complies with § 23-80-306(a).

History. Acts 1981, No. 517, § 4; A.S.A. 1947, § 66-5804.

Property and Casualty Insurance Guaranty Act, § 23-90-101 et seq.

Cross References. Casualty insurance contracts, § 23-89-101 et seq.

Property insurance contracts, § 23-88-101.

23-80-305. Powers of the commissioner.

(a) After notice and hearing, the Insurance Commissioner may issue reasonable rules or regulations implementing §§ 23-80-306 and 23-80-308.

(b) At the commissioner’s sole discretion, he or she may extend any dates under this subchapter.

(c) The commissioner shall have sole authority to enforce the provisions of this subchapter or seek remedies for its violation.

History. Acts 1981, No. 517, § 8; A.S.A. 1947, § 66-5808.

23-80-306. Minimum standards.

(a) All policies which, under subsection (b) of this section, must comply with this subsection shall be simplified, taking into consideration the following factors:

- (1) Use of simple sentence structure and short sentences;
- (2) Use of commonly understood words;
- (3) Avoidance of technical legal terms whenever possible;
- (4) Minimal reference to other sections or provisions of the policy;

(5) Organization of text; and

(6) Legibility.

(b)(1)(A) In addition to any other requirements of law, the Insurance Commissioner shall by regulation specify the dates by which personal lines policies shall comply with subsection (a) of this section.

(B) The dates established by the commissioner for compliance shall not be less than eighteen (18) months nor more than thirty-six (36) months from the effective date of the regulation.

(C) "Personal lines policies" are policies:

(i) Solely used to provide homeowners' insurance, dwelling fire insurance on one (1) to four (4) family units, or individual fire insurance on dwelling contents; or

(ii) Principally used to provide primary insurance on private passenger nonfleet automobiles individually owned and used for personal or family needs.

(2) In addition to any other requirements of law, the commissioner may by regulations specify which policies, other than those described in subdivision (b)(1) of this section, shall comply with subsection (a) of this section. The dates, if any, established by the commissioner for compliance may not be less than forty-eight (48) months from June 17, 1981, or twenty-four (24) months from the effective date of the regulation establishing the dates, whichever is later.

History. Acts 1981, No. 517, §§ 5, 6;
A.S.A. 1947, §§ 66-5805, 66-5806.

23-80-307. Compliance with other statutorily required language.

(a) The requirements of any other laws which specify the language or content of any policy may be met by a policy complying with § 23-80-306(a).

(b) However, the policy must provide protection which, considered as a whole, is not less favorable to the insured than is required by the other laws.

History. Acts 1981, No. 517, § 9;
A.S.A. 1947, § 66-5809.

23-80-308. Compliance by provision of outline of coverage.

An insurer may comply with § 23-80-306(a) and (b)(2) for not more than twelve (12) months following the implementation date established by the Insurance Commissioner by providing to the policyholder an outline of coverage or a brochure instead of a simplified policy. The outline or brochure shall comply with § 23-80-306(a).

History. Acts 1981, No. 517, § 7;
A.S.A. 1947, § 66-5807.

SUBCHAPTER 4 — PRESCRIPTION DRUG PAPERWORK SIMPLIFICATION

SECTION.

- 23-80-401. Purpose.
- 23-80-402. Definitions.
- 23-80-403. Exemptions.
- 23-80-404. Uniform card requirement.
- 23-80-405. Enrollment.

SECTION.

- 23-80-406. Required fields.
- 23-80-407. Compliance date.
- 23-80-408. Scope of authority.
- 23-80-409. Enabling clause.

Effective Dates. Acts 2001, No. 1409, § 10: Apr. 9, 2001. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that sixty-eight percent (68%) of a pharmacist's professional time is spent dealing with issues unrelated to patient care; that pharmacists are currently spending at least twenty percent (20%) of their professional time serving as intermediaries between patients and insurance companies; that prescription benefit cards vary dramatically between the many various health benefit plans; that surveys and studies indicate that the lack of a uniform prescription drug information card is a primary impediment to the productivity of pharmacists; that requiring the use of a standardized prescription drug information card will benefit both pharmacists and patients by decreasing stress and frustration and enhancing opportunities for patient interaction resulting in better use of medication, improved health outcomes, reduced health costs and convenience for consumers; that the immediate passage of this act is necessary to improve care to patients by minimizing confusion, eliminating unnecessary paperwork, decreasing administrative burdens and streamlining dispensing of pre-

scription products paid for by third party payors. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto."

Acts 2003, No. 1473, § 74: July 1, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act includes technical corrects to Act 923 of 2003 which establishes the classification and compensation levels of state employees covered by the provisions of the Uniform Classification and Compensation Act; that Act 923 of 2003 will become effective on July 1, 2003; and that to avoid confusion this act must also effective on July 1, 2003. Therefore, an emergency is declared to exist and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2003."

23-80-401. Purpose.

It is the intent of the General Assembly to improve care to patients by minimizing confusion, eliminating unnecessary paperwork, decreasing administrative burdens, and streamlining dispensing of prescription products paid for by third-party payors. This subchapter shall be construed liberally to effectuate this purpose.

History. Acts 2001, No. 1409, § 1.

23-80-402. Definitions.

As used in this subchapter:

- (1) “Commissioner” means the Insurance Commissioner;
- (2) “Covered person” means a person on whose behalf a health benefit plan is obligated to pay benefits pursuant to the health benefit plan; and
- (3) “Health benefit plan” means any individual, blanket, or group plan, policy, certificate, or contract for health care services issued or delivered in this state, including indemnity plans, managed care plans, plans provided or arranged by fraternal benefit societies, plans provided or arranged by health maintenance organizations, health governmental plans as defined in 29 U.S.C. 1002(32), as in effect January 1, 2001, plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as in effect January 1, 2001, or by any waiver of or other exception to that act provided under federal law or regulation, as in effect January 1, 2001.

History. Acts 2001, No. 1409, § 2.

this section, is codified at 29 U.S.C. § 1001 et seq.

U.S. Code. The Employee Retirement Income Security Act of 1974, referred to in

23-80-403. Exemptions.

This subchapter shall not apply to:

- (1) Accidental injury insurance plans;
- (2) Dental insurance plans;
- (3) Vision insurance plans;
- (4) Specified disease insurance plans;
- (5) Disability income plans;
- (6) Credit insurance plans;
- (7) Insurance coverage issued as a supplement to liability insurance;
- (8) Medical payments under automobile or homeowners insurance plans;
- (9) Health benefit plans provided pursuant to Arkansas Constitution, Article 5, § 32, the Workers’ Compensation Law, § 11-9-101 et seq., and the Public Employee Workers’ Compensation Act, § 21-5-601 et seq.;
- (10) Insurance under which benefits are payable with or without regard to fault and the benefits that are statutorily required to be contained in any liability policy or equivalent self-insurance; and
- (11) Plans that provide only indemnity for hospital confinement.

History. Acts 2001, No. 1409, § 3.

23-80-404. Uniform card requirement.

- (a) Every health benefit plan that provides coverage for prescription drugs or devices and issues a card or other technology for claims

processing and every administrator of such plans, including third-party administrators for self-insured plans, pharmacy benefit managers, and administrators of state plans, shall issue to all covered persons a uniform card or other technology containing uniform prescription drug information as required under this subchapter.

(b) The uniform prescription drug information card or other technology shall:

(1)(A) Be in a format approved by the National Council for Prescription Drug Programs, in which case the card or other technology shall include all fields of information required by the council and conform to the most recent pharmacy information card or other technology implementation guide produced by the council.

(B) In the alternative, the card or other technology shall conform to a national format established in an administrative rule by the Insurance Commissioner;

(2) Include in a clear, readable, and understandable manner all information, exclusive of information provided on the prescription as required by law or regulation, that is necessary to process a claim for prescription drug benefits under the health benefit plan;

(3) Format and arrange all information on the card or other technology in a manner that corresponds both in content and format to the content and format required by the health benefit plan to process the claim for prescription drug benefits;

(4) Conform all information on the card or other technology not specified by the council to a content and format established in an administrative rule by the commissioner; and

(5) If the health benefit plan requires a conditional or situational field as defined by the council, conform the conditional or situational field to the most recent pharmacy information card or other technology implementation guide produced by the council or to a national format established in an administrative rule by the commissioner.

History. Acts 2001, No. 1409, § 4; 2003, No. 1473, § 54.

Amendments. The 2003 amendment in (b)(1)(A), deleted the (i) through (iii) designations, inserted “in which case the

card or other technology shall,” and made related changes; and inserted “In the alternative, the card or other technology shall” in (b)(1)(B).

23-80-405. Enrollment.

(a) Upon enrollment of a covered person, a health benefit plan shall issue a uniform prescription drug information card or other technology in accordance with the requirements of § 23-80-404.

(b) Upon any change in a covered person’s coverage that impacts in content or format any information contained on a uniform prescription drug information card or other technology, a health benefit plan shall issue new uniform prescription drug information cards or other technology to all covered persons in accordance with the requirements of § 23-80-404.

(c)(1) A newly issued uniform prescription drug information card or other technology shall be updated with the latest coverage information and shall conform to the standards of the National Council for Prescription Drug Programs then in effect, and to the implementation guide then in use, or a national format established in an administrative rule by the Insurance Commissioner.

(2) However, a health benefit plan may issue stickers to covered persons to update cards as may be established in an administrative rule by the commissioner.

History. Acts 2001, No. 1409, § 5.

23-80-406. Required fields.

(a) This subchapter does not require a health benefit plan that provides coverage for prescription drugs or devices to issue a card or other technology separate from any identification card issued to a covered person to evidence coverage under the health benefit plan, if the card or other technology contains all of the required fields of information established by the National Council for Prescription Drug Programs, as in effect January 1, 2001, that are necessary to process a claim for prescription drug benefits under the health benefit plan.

(b) The required fields of information shall be included on the card in a substantially similar format to that established by the council, as in effect January 1, 2001, and shall be printed in a clear, readable, and understandable manner.

History. Acts 2001, No. 1409, § 6.

23-80-407. Compliance date.

All prescription drug information cards or other technologies, including dual-use identification cards described in § 23-80-406, that are executed, delivered, issued, modified, extended, or renewed by a health benefit plan shall comply with the requirements of this subchapter.

History. Acts 2001, No. 1409, § 7.

this section ended with the phrase “within two (2) years after April 9, 2001.”

A.C.R.C. Notes. As originally codified,

23-80-408. Scope of authority.

The Insurance Commissioner shall have all the powers to enforce this subchapter that are granted to the commissioner elsewhere in the Arkansas Insurance Code.

History. Acts 2001, No. 1409, § 8.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-80-409. Enabling clause.

The Insurance Commissioner shall promulgate regulations necessary to implement this subchapter and shall look for guidance to the standards and implementation guides produced by the National Council for Prescription Drug Programs.

History. Acts 2001, No. 1409, § 9.

CHAPTER 81**LIFE INSURANCE POLICIES AND ANNUITIES****SUBCHAPTER.**

1. GENERAL PROVISIONS.
2. STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE.
3. STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES.
4. VARIABLE CONTRACTS.
5. VIATICAL SETTLEMENTS ACT. [REPEALED.]
6. VIATICAL SETTLEMENTS ACT.

RESEARCH REFERENCES

ALR. Life insurance: liability of insurer for damages resulting from delay in passing upon an application for. 1 ALR 4th 1202.

Insurer's tort liability for wrongful or negligent issuance of life policy. 37 ALR 4th 972.

Life insurance: liability of agent or broker to insured for misrepresentation of cash surrender value or accumulated value benefits or policy. 44 ALR 4th 1030.

Method of valuation of life insurance policies in connection with trial court's division of property in divorce or separation. 54 ALR 4th 1203.

Credit life insurer's punitive damage liability for refusing liability. 55 ALR 4th 246.

Insurance anti-rebate statutes. 90 ALR 4th 213.

Am. Jur. 43 Am. Jur. 2d, Ins., § 533 et seq.

SUBCHAPTER 1 — GENERAL PROVISIONS**SECTION.**

- 23-81-101. Title required.
- 23-81-102. Scope.
- 23-81-103. Life insurance — Standard provisions required.
- 23-81-104. Life insurance — Grace period provision.
- 23-81-105. Life insurance — Incontestability provision.
- 23-81-106. Life insurance — Integrity of contract and alteration of contract provisions.
- 23-81-107. Life insurance — Misstatement of age provision.
- 23-81-108. Life insurance — Dividend provision.

SECTION.

- 23-81-109. Life insurance — Adjustment of loan interest rates provision.
- 23-81-110. Life insurance — Table of installments provision.
- 23-81-111. Life insurance — Reinstatement provision.
- 23-81-112. Life insurance — Payment of premiums provision.
- 23-81-113. Life insurance — Payment of claims provision.
- 23-81-114. Life insurance — Excluded or restricted coverage clauses limited.
- 23-81-115. Life insurance — Limitation

SECTION.

- of liability.
- 23-81-116. Life insurance — Holding of proceeds.
- 23-81-117. Life insurance — Indebtedness deducted from proceeds.
- 23-81-118. Life insurance — Refund of certain premiums and payment of proceeds.
- 23-81-119. [Repealed.]
- 23-81-120. Life insurance — Unnamed beneficiaries prohibited.
- 23-81-121. Annuity and pure endowment contracts — Standard provisions required.
- 23-81-122. Annuity and pure endowment contracts — Grace period provision.
- 23-81-123. Annuity and pure endowment contracts — Incontestability provision.
- 23-81-124. Annuity and pure endowment contracts — Integrity of contract provision.
- 23-81-125. Annuity and pure endowment contracts — Misstatement of age provision.
- 23-81-126. Annuity and pure endowment contracts — Dividend provision.
- 23-81-127. Annuity and pure endowment contracts — Reinstatement

SECTION.

- ment provision.
- 23-81-128. Reversionary annuities — Standard provisions required.
- 23-81-129. Incontestability of life insurance policy or annuity contract after reinstatement.
- 23-81-130. Registered life insurance policies and annuity contracts — Deposit of reserves.
- 23-81-131. Registered life insurance policies and annuity contracts — Certificate.
- 23-81-132. Registered life insurance policies and annuity contracts — Valuation.
- 23-81-133. Registered life insurance policies and annuity contracts — Mutilated or surrendered policies.
- 23-81-134. Registered life insurance policies and annuity contracts — Maintenance of deposit — Commissioner's duty to issue certificate.
- 23-81-135. Registered life insurance policies and annuity contracts — Credit of certain deposits.
- 23-81-136. Registered life insurance policies and annuity contracts — Deficiency of deposit.

Cross References. Manner of payment of claims, § 23-63-107.

Effective Dates. Acts 1977, No. 789, § 10: Mar. 28, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health, and safety shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 522, § 53: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

23-81-101. Title required.

There shall be a title on the policy briefly describing it.

History. Acts 1959, No. 148, § 322;
A.S.A. 1947, § 66-3313.

23-81-102. Scope.

(a) This section, §§ 23-81-101, 23-81-103 — 23-81-117, 23-81-120 — 23-81-136, and the Standard Nonforfeiture Law for Life Insurance, § 23-81-201 et seq., apply to contracts of life insurance and annuities, other than reinsurance, group life insurance, group annuities, and industrial life insurance.

(b) However, the following statutes shall also apply to industrial life insurance:

- (1) Section 23-81-114, excluded or restricted coverage;
- (2) Section 23-81-115, limitation of liability;
- (3) Section 23-81-129, incontestability after reinstatement;
- (4) Section 23-81-120, prohibited policy plans; and
- (5) The Standard Nonforfeiture Law for Life Insurance, § 23-81-201 et seq.

History. Acts 1959, No. 148, § 310;
A.S.A. 1947, § 66-3301.

23-81-103. Life insurance — Standard provisions required.

(a) No policy of life insurance, other than credit life, industrial, group, and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions required by §§ 23-81-101 and 23-81-104 — 23-81-112.

(b) This section shall not apply to annuity contracts nor to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(c) Any of the provisions or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated therein.

History. Acts 1959, No. 148, § 311;
A.S.A. 1947, § 66-3302.

23-81-104. Life insurance — Grace period provision.

(a) There shall be a provision that a grace period of thirty (30) days, or, at the option of the insurer, of one (1) month of not less than thirty (30) days, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force.

(b) However, if a claim arises under the policy during that period of grace, the amount of any premium due or overdue may be deducted from the policy proceeds.

History. Acts 1959, No. 148, § 312;
A.S.A. 1947, § 66-3303.

23-81-105. Life insurance — Incontestability provision.

There shall be a provision that, except for fraud in the procurement, the policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue. However, at its option, the insurer may omit from the provision the phrase “except for fraud in the procurement”.

History. Acts 1959, No. 148, § 313;
A.S.A. 1947, § 66-3304; Acts 2001, No.
1382, § 1.

inserted “except for fraud in the procure-
ment” following “provision that,” and
added the last sentence.

Amendments. The 2001 amendment

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation
in Procurement of Insurance: The Arkan-
sas Law, 4 UALR L.J. 17.

Survey of Legislation, 2001 Arkansas
General Assembly, Insurance Law, 24
UALR L.J. 577.

CASE NOTES

Cited: Life & Cas. Ins. Co. v. Smith, 245
Ark. 934, 436 S.W.2d 97 (1969).

23-81-106. Life insurance — Integrity of contract and alteration of contract provisions.

(a) There shall be a provision that the policy, or the policy and the application therefor if a copy of the application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties and that all statements contained in the application, in the absence of fraud, shall be deemed representations and not warranties.

(b) At the option of the insurer, there shall be a provision that no agent shall have the power or authority to waive, change, or alter any of the terms or conditions of any policy, except that at the option of the insurer the terms or conditions may be changed by an endorsement or rider signed by an authorized officer of the insurer.

History. Acts 1959, No. 148, § 314;
A.S.A. 1947, § 66-3305.

CASE NOTES

Oral Contracts.

There is nothing in the Arkansas statutes that would invalidate an oral con-

tract for life insurance. *Constitution Life Ins. Co. v. M.D. Thompson & Son*, 251 Ark. 784, 475 S.W.2d 165 (1972).

23-81-107. Life insurance — Misstatement of age provision.

(a) There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age.

(b) As to overstatement of age, the policy may provide, in lieu of the provisions required under subsection (a) of this section, that the insurer will refund any excess of premium collected for the amount of insurance or benefit stated in the policy, as based upon the correct age.

History. Acts 1959, No. 148, § 315; A.S.A. 1947, § 66-3306.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-81-108. Life insurance — Dividend provision.

(a) There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy, provided that the policy is in force and all premiums to that date are paid. Except as provided in this section, any dividend becoming payable shall, at the option of the party entitled to elect such an option, be either:

(1) Payable in cash; or

(2)(A) Applied to any one (1) of such other dividend options as may be provided by the policy.

(B) If other dividend options are provided, the policy shall further state which option shall be automatically effective if the party has not elected some other option.

(C) If the policy specified a period within which the other dividend option may be elected, the period shall be not less than thirty (30) days following the date on which the dividend is due and payable.

(D) The annually apportioned dividend shall be deemed to be payable in cash within the meaning of subdivision (a)(1) of this section, even though the policy provides that payment of the dividend is to be deferred for a specified period, provided that the period does not exceed six (6) years from the date of apportionment and that, if so

provided in the policy, interest will be added to the dividend at a specified rate.

(E) If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under a nonforfeiture provision shall be applied in the manner set forth in the policy.

(b) "Divisible surplus" as used in subsection (a) of this section, subject, in the case of domestic insurers, to § 23-69-126, means that part of the insurer's total surplus which is determined by the insurer's board of directors to be available for distribution to policyholders. The matters set forth in this subsection need not be contained in the policy.

History. Acts 1959, No. 148, § 316;
A.S.A. 1947, § 66-3307.

23-81-109. Life insurance — Adjustment of loan interest rates provision.

(a) **PURPOSE.** The purpose of this section is to permit and set guidelines for life insurers to include in life insurance policies issued after June 17, 1981, a provision for periodic adjustment of policy loan interest rates.

(b) **DEFINITIONS.** For purposes of this section, the "published monthly average" means:

(1) Moody's Corporate Bond Yield Average — Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto; or

(2) In the event that Moody's Corporate Bond Yield Average — Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Insurance Commissioner.

(c) **MAXIMUM RATE OF INTEREST ON POLICY LOANS.**

(1) Policies issued on or after June 17, 1981, shall provide for policy loan interest rates as follows:

(A) A provision permitting a maximum interest rate of not more than eight percent (8%) per annum; or

(B) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law and subject to any applicable usury limitation.

(2) The rate of interest charged on a policy loan made under subdivision (c)(1)(B) of this section shall not exceed the higher of the following:

(A) The published monthly average for the calendar month ending two (2) months before the date on which the rate is determined; or

(B) The rate used to compute the cash surrender values under the policy during the applicable period plus one percent (1%) per annum.

(3) If the maximum rate of interest is determined pursuant to subdivision (c)(1)(B) of this section, the policy shall contain a provision

setting forth the frequency at which the rate is to be determined for that policy.

(4) The maximum rate for each policy must be determined at regular intervals at least one (1) time every twelve (12) months, but not more frequently than one (1) time in any three-month period. At the intervals specified in the policy:

(A) The rate being charged may be increased whenever the increase as determined under subdivision (c)(2) of this section would increase that rate by one-half of one percent ($\frac{1}{2}$ of 1%) or more per annum; and

(B) The rate being charged must be reduced whenever a reduction as determined under subdivision (c)(2) of this section would decrease that rate by one-half of one percent ($\frac{1}{2}$ of 1%) or more per annum.

(5) The life insurer shall:

(A) Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(B) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in subdivision (c)(5)(C) of this section;

(C) Send to policyholders with loans reasonable advance notice of any increase in the rate; and

(D) Include in the notices required in this subdivision (c)(5) the substance of the pertinent provisions of subdivisions (c)(1) and (3) of this section.

(6)(A) The loan value of the policy shall be at least equal to the cash surrender value at the end of the then-current policy year, provided that the insurer may deduct, either from the loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining the cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and interest on the loan to the end of the current policy year.

(B) No policy shall terminate in a policy year as the sole result of change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(7) The substance of the pertinent provisions of subdivisions (c)(1) and (3) of this section shall be set forth in the policies to which they apply.

(d) DEFINITIONS. For purposes of this section:

(1) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

(2) The term "policy loan" includes any premium loan made under a policy to pay one (1) or more premiums that were not paid to the life insurer as they fell due;

(3) The term “policyholder” includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and

(4) The term “policy” includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(e) OTHER PROVISIONS. No other provision of law shall apply to policy loan interest rates unless made specifically applicable to the rates.

(f) APPLICABILITY TO EXISTING POLICIES. The provisions of this section shall not apply to any insurance contract issued before June 17, 1981.

History. Acts 1959, No. 148, § 317; 1977, No. 279, § 1; 1981, No. 915, § 1; 1983, No. 522, §§ 28, 29; A.S.A. 1947, § 66-3308.

Publisher's Notes. Acts 1983, No. 522, § 51, provided, in part, that the act

would be cumulative of prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

23-81-110. Life insurance — Table of installments provision.

In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments per stated unit.

History. Acts 1959, No. 148, § 318; A.S.A. 1947, § 66-3309.

23-81-111. Life insurance — Reinstatement provision.

There shall be a provision that unless the policy has been surrendered for its cash surrender value or its cash surrender value has been exhausted, or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three (3) years from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy, all with interest at a rate not exceeding six percent (6%) per annum compounded annually.

History. Acts 1959, No. 148, § 319; A.S.A. 1947, § 66-3310.

23-81-112. Life insurance — Payment of premiums provision.

There shall be a provision relative to the payment of premiums.

History. Acts 1959, No. 148, § 320; A.S.A. 1947, § 66-3311.

23-81-113. Life insurance — Payment of claims provision.

(a) There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of

due proof of death and, at the insurer's option, surrender of the policy or proof of the interest of the claimant, or both surrender and proof.

(b) If any insurer shall specify a particular period prior to the expiration of which settlement shall be made, the period shall not exceed two (2) months from the receipt of the proofs.

History. Acts 1959, No. 148, § 321;
A.S.A. 1947, § 66-3312.

CASE NOTES

ANALYSIS

Insurer's liability.
Investigation exception.

Insurer's Liability.

Failure to pay a claim within 60 days of receipt of proof of loss does not result in automatic liability under the penal provisions of § 23-79-208; an insurer has a reasonable time to investigate a claim, and what is reasonable depends on the facts and circumstances of the case. *McKee v. Federal Kemper Life Assurance Co.*, 726 F. Supp. 245 (E.D. Ark. 1989), *aff'd*, 927 F.2d 326 (8th Cir. 1991).

Where insurer had full knowledge of the family dispute and set a deadline for the parties to resolve their differences, and where the insurer failed to take any action

until after the deadline had passed, after the expiration of the sixty-day limit of subsection (b) of this section, and after one of the claimant's filed suit, insurer was liable for the penalties prescribed by § 23-79-208(a). *Minnesota Mut. Life Ins. Co. v. Looney*, 55 Ark. App. 384, 935 S.W.2d 3 (1996).

Investigation Exception.

The Arkansas Supreme Court has construed § 23-79-208 to allow insurers to conduct a reasonable and timely investigation, and the district court did not err in concluding that the exception continues to apply even when the mandatory two-month period of subsection (b) governs the payment of the insurance claim. *McKee v. Federal Kemper Life Assurance Co.*, 927 F.2d 326 (8th Cir. 1991).

23-81-114. Life insurance — Excluded or restricted coverage clauses limited.

A clause in any policy of life insurance providing that the policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy. Such a clause shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the clause.

History. Acts 1959, No. 148, § 323;
A.S.A. 1947, § 66-3314.

23-81-115. Life insurance — Limitation of liability.

(a) No policy of life insurance shall be delivered or issued for delivery in this state if it contains any of the following provisions:

(1) A provision for a period shorter than that provided by statute within which an action at law or in equity may be commenced on such a policy;

(2) A provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a

specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one (1) or more of the following circumstances:

(A) Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of the war or action, or of service in the military, naval, or air forces or in civilian forces auxiliary thereto, or from any cause while a member of the military, naval, or air forces of any country at war, declared or undeclared, or of any country engaged in the military action;

(B) Death as a result of aviation or any air travel or flight;

(C) Death as a result of a specified hazardous occupation or occupations;

(D) Death while the insured is a resident outside the continental United States and Canada; or

(E) Death within two (2) years from the date of issue of the policy or within two (2) years of the effective date of any increase in the face amount of the policy as a result of suicide, while sane or insane. However, the parts of this subdivision (a)(2)(E) applicable to increases in the face amount of the policy shall apply only to the additional amount.

(b) A policy which contains any exclusion or restriction pursuant to subsection (a) of this section shall also provide that in the event of death under the circumstances to which any exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the Insurance Commissioner's reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits, or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy, with adjustment for indebtedness or dividend credit.

(c) This section shall not apply to group life insurance, disability insurance, reinsurance, or annuities, or to any provision in a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(d) Nothing contained in this section shall prohibit any provision which, in the opinion of the commissioner, is more favorable to the policyholder than a provision permitted by this section.

History. Acts 1959, No. 148, § 332; 1983, No. 522, § 46; A.S.A. 1947, § 66-3323.

Publisher's Notes. For cumulative effect of 1983 amendment to this section, see Publisher's Notes to § 23-81-109.

CASE NOTES

Suicide Clause.

Where an original policy taken out to protect a bank loan was replaced by a second policy when the amount of loan was increased and both policies contained

a two-year suicide clause pursuant to subdivision (a)(2)(E) of this section, and insured committed suicide within two years of issuance of a second policy but six years after issuance of the first, the insurer was

liable for the amount which would have been payable under the first policy, but not for the additional amount payable under the second. *Fisk v. Security Life & Trust Co.*, 575 F.2d 1242 (8th Cir. 1978).

Cited: *City of Hot Springs v. National Sur. Co.*, 258 Ark. 1009, 531 S.W.2d 8 (1975).

23-81-116. Life insurance — Holding of proceeds.

(a) Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder.

(b) Upon maturity of a policy, by death in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries.

(c) The insurer shall not be required to segregate the funds so held but may hold them as part of its general assets.

History. Acts 1959, No. 148, § 334;
A.S.A. 1947, § 66-3325.

CASE NOTES

Cited: *Wasson v. Pyron*, 242 Ark. 518, 414 S.W.2d 391 (1967).

23-81-117. Life insurance — Indebtedness deducted from proceeds.

In determining the amount due under any life insurance policy issued, deduction may be made of:

(1) Any unpaid premiums or installments thereof for the current policy year due under the terms of the policy; and

(2) The amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid.

History. Acts 1959, No. 148, § 335;
A.S.A. 1947, § 66-3326.

23-81-118. Life insurance — Refund of certain premiums and payment of proceeds.

(a) Upon the death of an insured, the proceeds payable to the beneficiary under any policy of individual life insurance, delivered or issued for delivery in this state after July 20, 1979, that is in force on a premium-paying basis on the date of death shall include premiums paid for any period beyond the end of the policy month in which death occurred unless the refund of premiums is due some other person pursuant to contract provisions.

(b)(1) When proceeds of any individual policy of life insurance, delivered or issued for delivery in this state, or refunds of premiums on any individual policy of life insurance delivered or issued for delivery in this state after July 20, 1979, are not paid within a reasonable period of time after proof of the death of the insured has been furnished to the insurer, the insurer shall pay interest upon the proceeds or refunds of premiums at the rate of eight percent (8%) per year.

(2) For the purpose of this section, a reasonable period of time shall be that period of time sufficient to complete an investigation of the cause of death and to process the necessary claims. In no case shall this period exceed thirty (30) days from the date proof of death of the insured has been furnished to the insurer.

(c) Unearned premiums shall be paid in a lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer. If not paid within thirty (30) days after proof of the insured's death has been furnished the insurer, interest upon any unpaid proceeds and any unearned premiums shall accrue interest from the date of the insured's death.

(d) Nothing in this section shall be construed to require a refund of premiums on single premium policies.

History. Acts 1979, No. 312, §§ 1-4; A.S.A. 1947, §§ 66-3312.1 — 66-3312.4; Acts 2001, No. 1382, § 2.

substituted "premiums and payment of" for "premiums with" in the section heading.

Amendments. The 2001 amendment

RESEARCH REFERENCES

Ark. L. Notes. Brill, A Primer on Judgment and Pre-Judgment Interest in Arkansas, 1989 Ark. L. Notes 1.

UALR L.J. Strother, Survey of Insurance Law, 3 UALR L.J. 242.

CASE NOTES

Penalty and Attorney's Fees.

There is no conflict in the awarding of pre-judgment interest pursuant to this section and, in addition, awarding a stat-

utory penalty and attorney's fees pursuant to § 23-79-208. *USAA Life Ins. Co. v. Boyce*, 294 Ark. 575, 745 S.W.2d 136 (1988).

23-81-119. [Repealed.]

Publisher's Notes. This section, concerning refund of certain life insurance premiums upon cancellation, was re-

pealed by Acts 1987, No. 456, § 16. The section was derived from Acts 1983, No. 710, § 1; A.S.A. 1947, § 66-3259.

23-81-120. Life insurance — Unnamed beneficiaries prohibited.

(a) No life insurance policy shall be issued or delivered in this state if it provides that on the death of anyone not specifically named therein, the owner or beneficiary of the policy shall receive the payment or granting of anything of value.

(b) This provision shall not be deemed to prohibit:

(1) The payment to policyholders or beneficiaries of sums representing in whole or in part gains to the insurer from mortality either in general or as resulting from particular classifications of policies;

(2) Family policies insuring unspecified members of a family; or

(3) Payments to unspecified beneficiaries of a class named by the insured.

History. Acts 1959, No. 148, § 345;
1977, No. 789, § 7; A.S.A. 1947, § 66-3336.

23-81-121. Annuity and pure endowment contracts — Standard provisions required.

(a) No annuity or pure endowment contract, other than reversionary annuities, survivorship annuities, or group annuities and except as stated in this section, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in §§ 23-81-122 — 23-81-127. Any of the provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

(b) This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

History. Acts 1959, No. 148, § 324;
A.S.A. 1947, § 66-3315.

23-81-122. Annuity and pure endowment contracts — Grace period provision.

(a) In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that there shall be a period of grace of one (1) month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum for the number of days of grace elapsing before the payment, during which period of grace the contract shall continue in full force.

(b) However, in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payment of the current contract year, if any, are made, the amount of the payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

History. Acts 1959, No. 148, § 325;
A.S.A. 1947, § 66-3316.

23-81-123. Annuity and pure endowment contracts — Incontestability provision.

If any statements, other than those relating to age, sex, and identity, are required as a condition to issuing an annuity or pure endowment contract, other than reversionary, survivorship, or group annuity, and subject to § 23-81-125, there shall be a provision that, except for fraud in the procurement, the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom the statements are required, for a period of two (2) years from its date of issue except for nonpayment of stipulated payments to the insurer. At the option of the insurer, the contract may also except any provisions relative to benefits in the event of disability and any provisions that grant insurance specifically against death by accident or accidental means. Furthermore, at its option, the insurer may omit from the provision the phrase “except for fraud in the procurement”.

History. Acts 1959, No. 148, § 326; A.S.A. 1947, § 66-3317; Acts 2001, No. 1382, § 3.

inserted “except for fraud in the procurement” following “provision that,” and added the last sentence.

Amendments. The 2001 amendment

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-81-124. Annuity and pure endowment contracts — Integrity of contract provision.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application shall constitute the entire contract between the parties.

History. Acts 1959, No. 148, § 327; A.S.A. 1947, § 66-3318.

23-81-125. Annuity and pure endowment contracts — Misstatement of age provision.

In an annuity or pure endowment contract, other than reversionary, survivorship, or group annuity, there shall be a provision that if the age of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payments to the insurer would have purchased according to the correct age, and that if the insurer shall make or has made any overpayments on account of any misstatement, the amount thereof, with interest at the rate to be

specified in the contract but not exceeding six percent (6%) per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

History. Acts 1959, No. 148, § 328;
A.S.A. 1947, § 66-3319.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-81-126. Annuity and pure endowment contracts — Dividend provision.

If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

History. Acts 1959, No. 148, § 329;
A.S.A. 1947, § 66-3320.

23-81-127. Annuity and pure endowment contracts — Reinstatement provision.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract may be reinstated at any time within one (1) year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum payable annually. In cases when applicable, the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

History. Acts 1959, No. 148, § 330;
A.S.A. 1947, § 66-3321.

23-81-128. Reversionary annuities — Standard provisions required.

(a) Except as stated in this section, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the following provisions:

(1) Any reversionary annuity contract shall contain the provisions specified in §§ 23-81-122 — 23-81-126, except that under § 23-81-122 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue or

deferred payment in lieu of providing for deduction of the payments from an amount payable upon settlement under the contract; and

(2) In reversionary annuity contracts, there shall be a provision that the contract may be reinstated at any time within three (3) years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the issuer on account of the contract be paid, or, within the limits permitted by the then-cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six percent (6%) per annum compounded annually.

(b) This section shall not apply to group annuities or to annuities included in life insurance policies, and any of the provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

History. Acts 1959, No. 148, § 331;
A.S.A. 1947, § 66-3322.

23-81-129. Incontestability of life insurance policy or annuity contract after reinstatement.

The reinstatement of any policy of life insurance or annuity contract delivered or issued for delivery in this state may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

History. Acts 1959, No. 148, § 333;
A.S.A. 1947, § 66-3324.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-81-130. Registered life insurance policies and annuity contracts — Deposit of reserves.

(a) A domestic life insurer existing on January 1, 1960, may deposit and shall thereafter maintain on deposit with the Insurance Commissioner securities and assets equal to the legal reserve on its registered life insurance policies and annuity contracts in force under the provisions of § 23-63-601 et seq. The securities and assets shall be held on deposit in trust for the common benefit of all the holders of the policies and contracts.

(b) However, no deposit shall be made or maintained as to industrial life insurance policies.

(c) All securities not negotiable by delivery and deposited by an insurer under this section shall be assigned to the commissioner and his or her successors in office, but the assignments shall be deemed to be conditional only and shall not be recorded unless and until the commissioner has revoked or refused to continue the insurer's certificate of authority or until the commissioner has applied to the court for receivership of the insurer in accordance with either § 23-68-106 or § 23-68-107.

(d) Deposits shall be subject to the applicable provisions of §§ 23-63-901 — 23-63-912, administration of deposits.

History. Acts 1959, No. 148, § 337; inserted "under the provisions of §§ 23-A.S.A. 1947, § 66-3328; Acts 2001, No. 63-601 et seq." at the end of the first sentence in (a). 1566, § 18.

Amendments. The 2001 amendment

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-81-131. Registered life insurance policies and annuity contracts — Certificate.

(a)(1) After making the deposit mentioned in § 23-81-130, the insurer shall not thereafter issue a registered policy life insurance or of endowment, or annuity bond or contract, unless the policy, bond, or contract shall have upon its face a certificate substantially in the following words: "This policy is registered, and approved securities equal in value to the legal reserve hereon are held in trust by the Commissioner of Insurance of the State of Arkansas."

(2) The certificate shall be signed by the Insurance Commissioner and sealed with the seal of the commissioner's office.

(b) Every insurer making a deposit under § 23-81-130 shall pay the commissioner for each certificate placed on registered policies, annuity bonds, or contracts issued by the insurer after the original or first deposit is made thereunder, a fee of twenty-five cents (25¢), and this fee so received shall be disposed of by the commissioner as follows:

(1) For payment of the annual rent or hire of the safe deposit box or custodial expense as provided for under § 23-63-904;

(2) Payment for the services of a competent and reliable representative of the commissioner, to be appointed by the commissioner, who shall have direct charge of the securities and safety box containing them, and through whom and under whose supervision the insurer may have access to its securities for the purposes provided in this section and §§ 23-81-130 and 23-81-132 — 23-81-136. The sum paid the representative shall not exceed the amount received from registration of policies by the insurer during any one (1) year; and

(3) The balance of the fees shall be paid to or deposited with the Treasurer of State to the credit of the General Fund.

History. Acts 1959, No. 148, §§ 338, 344; A.S.A. 1947, §§ 66-3329, 66-3335.

23-81-132. Registered life insurance policies and annuity contracts — Valuation.

(a) The insurer shall prepare and keep such records of all registered policies, bonds, or contracts issued by it and subject to § 23-81-131 as will enable the Insurance Commissioner to compute their value at any time.

(b) Upon proof that any of the policies, bonds, or contracts have been commuted or terminated, the insurer shall commute or cancel them upon its record. Until proof exists, all registered contracts shall be considered in force for the purposes of this section and §§ 23-81-130, 23-81-131, and 23-81-133 — 23-81-136.

(c) The net value of every policy, annuity bond, or contract, according to the standard prescribed by the laws of this state for the valuation of policies of life insurers, when the first premium shall have been paid thereon, less the amount of such liens as the insurer may have against it, not exceeding the value, shall be entered on the record of the policy, annuity bond, or contract at the time the record is made.

(d) On January 1 of each year, or within sixty (60) days thereafter, the insurer shall cause its registered policies, annuity bonds, or contracts to be carefully valued. The actual value of each at the time fixed for the valuation, less such liens as the insurer may have against it, not exceeding the value, shall be entered upon the insurer's record of the policy, bond, or contract.

History. Acts 1959, No. 148, § 339; A.S.A. 1947, § 66-3330.

23-81-133. Registered life insurance policies and annuity contracts — Mutilated or surrendered policies.

The Insurance Commissioner shall cancel mutilated or surrendered policies, annuity bonds, and contracts issued by any insurers subject to § 23-81-130 when surrendered to the commissioner and for the purpose of cancellation and certify other like policies, bonds, or contracts when issued in lieu thereof.

History. Acts 1959, No. 148, § 340; A.S.A. 1947, § 66-3331.

23-81-134. Registered life insurance policies and annuity contracts — Maintenance of deposit — Commissioner's duty to issue certificate.

(a)(1) Each insurer that has made the deposit provided for under § 23-81-130 shall make additional deposits from time to time in amounts not less than five thousand dollars (\$5,000) and of such securities as are permitted by §§ 23-63-901 — 23-63-912 to be depos-

ited so that the value of the securities deposited when valued as provided in §§ 23-63-601 et seq. and 23-84-101 — 23-84-111 shall always be equal to the current net value of the currently outstanding registered policies and annuity bonds and contracts issued by the insurer, less such liens as the insurer may have against it, not exceeding the net value.

(2) So long as the insurer maintains its deposits at an amount equal to or in excess of the net value of its registered policies, bonds, and contracts, the Insurance Commissioner shall sign and affix his or her seal to the certificates on every policy, annuity bond, or contract presented to him or her for that purpose by the insurer as provided in § 23-81-131.

(b) The obligation to maintain and increase the deposits shall be binding likewise upon any insurer that is a successor in interest to the issuing insurer as to the registered policies, bonds, or contracts.

History. Acts 1959, No. 148, § 341; A.S.A. 1947, § 66-3332; Acts 2001, No. 1566, § 19.

Amendments. The 2001 amendment, in (a), substituted “that” for “which,” sub-

stituted “§§ 23-63-601 et seq.” for “§§ 23-63-901 — 23-63-912,” substituted “it” for “them” preceding “not exceeding” in the first sentence, and made gender neutral changes.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001 Arkansas General Assembly, Insurance Law, 24 UALR L.J. 577.

23-81-135. Registered life insurance policies and annuity contracts — Credit of certain deposits.

A domestic life insurer which has made a deposit as to reserves pursuant to § 23-81-130 and which has also heretofore made a similar deposit with respect to its capital stock under laws heretofore in force may, to the extent that the deposit as to capital stock is composed of securities and assets eligible for deposit under § 23-63-903, credit the amount of the deposit as to capital upon the amount of deposit required as to such reserves.

History. Acts 1959, No. 148, § 342; A.S.A. 1947, § 66-3333.

23-81-136. Registered life insurance policies and annuity contracts — Deficiency of deposit.

(a) If at any time the value of the securities and assets held on deposit as to a particular insurer under § 23-81-130 is less than the actual value of the registered policies and annuity bonds or contracts issued by the insurer and then in force, the Insurance Commissioner shall not execute the certificate on any additional policies, annuity

bonds, or contracts of the insurer until it shall have made good the deficit.

(b) In the event of any deficiency in its deposit, the insurer shall also be subject to the provisions of § 23-63-910(b).

History. Acts 1959, No. 148, § 343; A.S.A. 1947, § 66-3334.

SUBCHAPTER 2 — STANDARD NONFORFEITURE LAW FOR LIFE INSURANCE

SECTION.

- 23-81-201. Title.
- 23-81-202. Applicability.
- 23-81-203. Nonforfeiture provisions.
- 23-81-204. Cash surrender value.
- 23-81-205. Certain paid-up benefits.
- 23-81-206. Calculation of adjusted premiums and present values issued before operative date of § 23-81-213(d).
- 23-81-207. Calculation of adjusted premiums and present values — Ordinary policies issued on or after operative date of § 23-81-213(b).
- 23-81-208. Calculation of adjusted premiums and present values — Industrial policies issued

SECTION.

- on or after operative date of § 23-81-213(c).
- 23-81-209. Calculation of adjusted premiums and present values — All policies issued on or after operative date of § 23-81-213(d).
- 23-81-210. Calculation of future adjusted premiums.
- 23-81-211. Calculation of certain cash surrender values and nonforfeiture benefits in event of default.
- 23-81-212. Calculation of cash surrender value in event of default.
- 23-81-213. Effective dates.

Effective Dates. Acts 1961, No. 466, § 13: Mar. 16, 1961. Emergency clause provided: “It has been found, and is hereby declared, that the use of the 1958 mortality tables authorized under this act, which tables take account of the improvement in the life expectancy of the American people since the 1941 table was developed, will greatly reduce the need for deficiency reserves required under current tables and will result in keeping down the cost of life insurance; and that since use of the 1958 mortality tables has already been approved in 31 states and will probably be approved by the remaining states during their current or next legislative session, prompt enactment of this Act is desirable so that policies may be issued on a uniform basis in all such states. Therefore, an emergency is hereby

declared to exist and this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in force from and after the date of its passage and approval.”

Acts 1977, No. 550, § 6: Mar. 18, 1977. Emergency clause provided: “It is hereby found and determined by the General Assembly that it is in the public interest that current money yields be recognized so as to give the benefit of these yields to policyholders of the State of Arkansas, and that this Act is necessary to accomplish these ends. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval.”

RESEARCH REFERENCES

Am. Jur. 44 Am. Jur. 2d, Ins., § 727 et seq.

23-81-201. Title.

This subchapter shall be known as the "Standard Nonforfeiture Law for Life Insurance".

History. Acts 1959, No. 148, § 336; 1977, No. 550, § 1; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-202. Applicability.

(a) This subchapter shall not apply to any of the following:

- (1) Reinsurance;
- (2) Group insurance;
- (3) Pure endowment;
- (4) Annuity or reversionary annuity contract;

(5) A term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before seventy-one (71) years of age, for which uniform premiums are payable during the entire term of the policy;

(6) A term policy of decreasing amount which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in §§ 23-81-206 — 23-81-209 is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty (20) years or less expiring before seventy-one (71) years of age, for which uniform premiums are payable during the entire term of the policy;

(7) A policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in §§ 23-81-204 — 23-81-209 exceeds two and one-half percent (2.5%) of the amount of insurance at the beginning of the same policy year; or

(8) A policy which shall be delivered outside this state through an agent or other representative of the insurer issuing the policy.

(b) For purposes of determining the applicability of this subchapter, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-203. Nonforfeiture provisions.

(a) In the case of policies issued on and after the operative date as defined in § 23-81-213(a), no policy of life insurance, except as stated in § 23-81-202, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding

provisions which in the opinion of the Insurance Commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section and are essentially in compliance with § 23-81-212:

(1) In the event of default in any premium payment, the insurer will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of such amount as may be specified. In lieu of the stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(2) Upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be specified;

(3) A specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such an election elects another available option not later than sixty (60) days after the due date of the premium in default;

(4) If the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of the amount as may be specified;

(5)(A) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy and, in the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter.

(B) The values and benefits shall be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy; and

(6) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered, an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy, if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that the method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered, and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy.

(b) Any of the provisions or portions thereof of subsection (a) of this section not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(c) The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-204. Cash surrender value.

(a) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by § 23-81-203, shall be an amount not less than the excess, if any, of the present value, on the anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(1) The then-present value of the adjusted premiums as defined in §§ 23-81-206 — 23-81-209 corresponding to premiums which would have fallen due on and after the anniversary; and

(2) The amount of any indebtedness to the insurer on the policy.

(b) However, for any policy issued on or after the operative date of § 23-81-207 as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value as defined in the section for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value as defined in the section for a policy which provides only the benefits otherwise provided by the rider or supplemental policy provision.

(c) For any family policy issued on or after the operative date of § 23-81-207 as defined therein, which defines a primary insured and

provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71), the cash surrender value referred to in subsection (a) of this section shall be an amount not less than the sum of the cash surrender value as defined in the section for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in the section for a policy which provides only the benefits otherwise provided by the term insurance on the life of the spouse.

(d) Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by § 23-81-203, shall be an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-205. Certain paid-up benefits.

Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this subchapter in the absence of the condition that premiums shall have been paid for at least a specified period.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-206. Calculation of adjusted premiums and present values issued before operative date of § 23-81-213(d).

(a)(1) This section shall not apply to policies issued on or after the operative date of § 23-81-213(d) as defined therein. Except as provided in subsection (c) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be the uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy of all adjusted premiums shall be equal to the sum of:

(A) The then-present value of the future guaranteed benefits provided for by the policy;

(B) Two percent (2%) of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as

hereinafter defined, if the amount of insurance varies with duration of the policy;

(C) Forty percent (40%) of the adjusted premium for the first policy year; and

(D) Twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(2) However, in applying the percentages specified in subdivisions (a)(1)(C) and (D) of this section, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or level amount equivalent thereto.

(3) The date of issue of a policy for the purpose of this subchapter shall be the date as of which the rated age of the insured is determined.

(b)(1) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount thereof for the purpose of this subchapter shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the inception of the insurance as the benefits under the policy.

(2) However, in the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount thereof for the purpose of subsection (a) of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy.

(3) However, in the case of a policy for a varying amount of insurance issued on the life of a child under ten (10) years of age, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of ten (10) years of age was the amount provided by the policy at ten (10) years of age.

(c)(1) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

(A) The adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits, are payable; by

(B) The adjusted premiums for the term insurance.

(2) Subdivisions (c)(1)(A) and (B) of this section shall be calculated separately and as specified in subsections (a) and (b) of this section except that, for the purposes of subdivisions (a)(1)(B)-(D) of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in

subdivision (c)(1)(B) of this section shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in subdivision (c)(1)(A) of this section.

(d)(1) Except as otherwise provided in §§ 23-81-207 and 23-81-208, all adjusted premiums and present values referred to in this subchapter shall for all policies of ordinary insurance be calculated on the basis of the Insurance Commissioner's 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three (3) years younger than the actual age of the insured, and the calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3.5%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

(2) However, in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty percent (130%) of the rates of mortality according to the applicable table.

(3) Further, for insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on another table of mortality as may be specified by the insurer and approved by the commissioner.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-1961, No. 466, §§ 3-5; 1965, No. 439, § 2; 3327.

23-81-207. Calculation of adjusted premiums and present values — Ordinary policies issued on or after operative date of § 23-81-213(b).

(a) In the case of ordinary policies issued on or after the operative date of § 23-81-213(b) as defined therein, all adjusted premiums and present values referred to in this subchapter shall be calculated on the basis of the Insurance Commissioner's 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

(b) The rate of interest shall not exceed three and one-half percent (3.5%) per annum except that a rate of interest not exceeding five and one-half percent (5.5%) per annum may be used for policies issued on or after March 18, 1977, except that for any single premium whole life or endowment insurance policy, a rate of interest not exceeding six and one-half percent (6.5%) per annum may be used.

(c) For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to

an age not more than six (6) years younger than the actual age of the insured.

(d) However, in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1958 Extended Term Insurance Table.

(e) Further, for insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

(f) This section shall not apply to ordinary policies issued on or after the operative date of § 23-81-213(d).

History. Acts 1959, No. 148, § 336; 1977, No. 550, § 2; 1981, No. 535, § 2; 1961, No. 466, § 5; 1965, No. 439, § 2; A.S.A. 1947, § 66-3327.

23-81-208. Calculation of adjusted premiums and present values — Industrial policies issued on or after operative date of § 23-81-213(c).

(a) In the case of industrial policies issued on or after the operative date of § 23-81-213(c) as defined therein, all adjusted premiums and present values referred to in this subchapter shall be calculated on the basis of the Insurance Commissioner's 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

(b) However, the rate of interest shall not exceed three and one-half percent (3.5%) per annum, except that a rate of interest not exceeding five and one-half percent (5.5%) per annum may be used for policies issued on or after March 18, 1977, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6.5%) per annum may be used.

(c) However, in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1961 Industrial Extended Term Insurance Table.

(d) Further, for insurance issued on a substandard basis, the calculations of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

(e) This section shall not apply to industrial policies issued on or after the operative date of § 23-81-213(d) as defined therein.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-1965, No. 439, § 2; 1977, No. 550, § 3; 3327.

23-81-209. Calculation of adjusted premiums and present values — All policies issued on or after operative date of § 23-81-213(d).

(a)(1) This section shall apply to all policies issued on or after the operative date of § 23-81-213(d) as defined therein.

(2) Except as provided in subsection (g) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be the uniform percentage of the respective premiums specified in the policy for each policy year, excluding:

(A) Amounts payable as extra premiums to cover impairments or special hazards; and

(B) Any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

(i) The then-present value of the future guaranteed benefits provided for by the policy;

(ii) One percent (1%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(iii) One hundred twenty-five percent (125%) of the nonforfeiture net level premium as defined in this section.

(3) However, in applying the percentage specified in subdivision (a)(2)(B)(iii) of this section, no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years.

(4) The date of issue of a policy for the purpose of this subchapter shall be the date as of which the rate age of the insured is determined.

(b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum, payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

(c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(d) Except as otherwise provided in subsection (g) of this section, the recalculated future adjusted premiums for any policy shall be a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all future adjusted premiums shall be equal to the excess of:

(1) The sum of the then-present value of the then-future guaranteed benefits provided for by the policy and the additional expense allowance, if any; over

(2) The then-cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(1) One percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(2) One hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing subdivisions (d)(1) and (2) of this section when:

(1) Subdivision (d)(2) of this section equals the sum of:

(A) The nonforfeiture net level premium applicable prior to the change multiplied by the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(B) The present value of the increase in future guaranteed benefits provided by the policy;

(2) Subdivision (d)(2) of this section equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(g) Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if it were issued to provide higher uniform amounts of insurance on the standard basis.

(h)(1) All adjusted premiums and present values referred to in this subchapter shall:

(A) For all policies of ordinary insurance, be calculated on the basis of the Insurance Commissioner's 1980 Standard Ordinary Mortality Table or at the election of the insurer for any one (1) or more specified plans of life insurance, the commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors;

(B) For all policies of industrial insurance, be calculated on the basis of the commissioner's 1961 Standard Industrial Mortality Table; and

(C) For all policies issued in a particular calendar year, be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section, for policies issued in that calendar year.

(2) However:

(A) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subchapter, for policies issued in the immediately preceding calendar year;

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available whether or not required by § 23-81-203 shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(C) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the commissioner's 1961 Industrial Extended Terms Insurance Table for policies of industrial insurance;

(E) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(F) Any ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the commissioner's 1980 Extended Term Insurance Table;

(G) Any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulations promulgated by the commissioner for use in determin-

ing the minimum nonforfeiture standard may be substituted for the commissioner's 1961 Standard Industrial Mortality Table or the commissioner's 1961 Industrial Extended Term Insurance Table;

(H) The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for the policy as defined in this subchapter, rounded to the nearest one-quarter of one percent (0.25%) and

(I) Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

Meaning of "this code". Acts 1959, No. 148, codified as set out in the note following § 23-74-306.

23-81-210. Calculation of future adjusted premiums.

(a) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in §§ 23-81-203 — 23-81-209:

(1) The Insurance Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §§ 23-81-203 — 23-81-209;

(2) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) The cash surrender values and paid-up nonforfeiture benefits provided by the plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this subchapter, as determined by regulations promulgated by the commissioner.

(b) Notwithstanding any other provision in the laws of the state, any policy, contract, or certificate providing life insurance under any plan must be affirmatively approved by the commissioner before it can be marketed, issued, delivered, or used in this state.

History. Acts 1959, No. 148, § 336; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-211. Calculation of certain cash surrender values and nonforfeiture benefits in event of default.

(a) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary.

(b) All values referred to in §§ 23-81-204 — 23-81-209 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death.

(c) The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide the additions.

(d) Notwithstanding the provisions of § 23-81-204, additional benefits are payable:

(1) In the event of death or dismemberment by accident or accidental means;

(2) In the event of total and permanent disability;

(3) As reversionary annuity or deferred benefits;

(4) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this subchapter would not apply;

(5) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child is twenty-six (26) years of age, is uniform in amount after the child's age is one (1) year, and has not become paid up by reason of the death of a parent of the child; and

(6) As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this subchapter, and no additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

History. Acts 1959, No. 148, § 336; 1961, No. 466, § 6; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-212. Calculation of cash surrender value in event of default.

(a) In addition to all other applicable sections of this subchapter, this section shall apply to all policies issued on or after January 1, 1985.

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent (0.2%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of:

(1) The greater of zero (0) and the basic cash value specified in subsection (c) of this section; and

(2) The present value of any existing paid-up additions, less the amount of any indebtedness to the company under the policy.

(c)(1) The basic cash value shall be equal to the present value, on the anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then-present value of the nonforfeiture factors, as defined in subsection (d) of this section, corresponding to premiums which would have fallen due on and after the anniversary.

(2) However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in § 23-81-204, shall be the same as are the effects specified in that section on the cash surrender values defined therein.

(d) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in § 23-81-209. Except as is required by subsection (e) of this section, the percentage must be:

(1) The same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent (0.2%) of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(2) Such that no percentage after the later of the two (2) policy anniversaries specified in subdivision (d)(1) of this section, and no percentage may apply to fewer than five (5) consecutive policy years.

(e) However, no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in § 23-81-209, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(f)(1) All adjusted premiums and present values referred to in this section for a particular policy shall be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this subchapter.

(2) The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

(g)(1) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in §§ 23-81-203 — 23-81-205, 23-81-209, and 23-81-211.

(2) The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits

such as those listed in § 23-81-211(d) shall conform with the principles of this section.

History. Acts 1959, No. 148, § 336; 1961, No. 466, § 6; 1981, No. 535, § 2; A.S.A. 1947, § 66-3327.

23-81-213. Effective dates.

(a) After January 1, 1960, any insurer may file with the Insurance Commissioner a written notice of its election to comply after a specified date before January 1, 1961. After the filing of the notice and then upon the specified date, which shall be the operative date for the insurer, this subsection shall become operative with respect to the policies thereafter issued by such an insurer. If an insurer makes no election, the operative date of this subsection for the insurer shall be January 1, 1961.

(b) After March 16, 1961, any insurer may file with the commissioner a written notice of its election to comply after a specified date before January 1, 1966. After the filing of the notice and then upon the specified date, which shall be the operative date for the insurer, this subsection shall become operative with respect to the policies thereafter issued by the insurer. If an insurer makes no election, the operative date of this subsection for the insurer shall be January 1, 1966.

(c) After January 1, 1960, any insurer may file with the commissioner a written notice of its election to comply after a specified date before January 1, 1969. After the filing of the notice and then upon the specified date, which shall be the operative date for the insurer, this subsection shall become operative with respect to the policies thereafter issued by such an insurer. If an insurer makes no election, the operative date of this subsection for the insurer shall be January 1, 1969.

(d) After January 1, 1982, any insurer may file with the commissioner a written notice of its election to comply after a specified date before January 1, 1989. After the filing of the notice and then upon the specified date, which shall be the operative date for the insurer, this subsection shall become operative with respect to the policies thereafter issued by the insurer. If an insurer makes no election, the operative date of this subsection for the insurer shall be January 1, 1989.

(e) After January 1, 1982, any insurer may file with the commissioner a written notice of its election to comply after a specified date before January 1, 1985. After the filing of the notice and then upon the specified date, which shall be the operative date for the insurer, this subsection shall become operative with respect to the policies thereafter issued by the insurer. If an insurer makes no election, the operative date of this subsection shall be January 1, 1985.

History. Acts 1959, No. 148, § 336; 1977, No. 550, § 2; 1981, No. 535, § 2; 1961, No. 466, §§ 5, 7; 1965, No. 439, § 2; A.S.A. 1947, § 66-3327.

SUBCHAPTER 3 — STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

SECTION.

- 23-81-301. Title.
 23-81-302. Applicability.
 23-81-303. Nonforfeiture requirements.
 23-81-304. Minimum values.
 23-81-305. Computation of present value.
 23-81-306. Calculation of cash surrender values.
 23-81-307. Calculation of paid-up annuity benefits.

SECTION.

- 23-81-308. Maturity date.
 23-81-309. Disclosure of limited death benefits.
 23-81-310. Inclusion of lapse-of-time considerations.
 23-81-311. Proration of values — Additional benefits.
 23-81-312. Operative date.

A.C.R.C. Notes. Acts 2003, No. 669, § 3: Mar. 26, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the present Standard Nonforfeiture Law for Individual Deferred Annuities places an undue economic burden on insurance companies that provide such products and could affect the financial stability of such companies and without change, the law as it is presently written could be detrimental to the Arkansas insurance consumer and could limit the

types of annuities available to Arkansas residents. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

RESEARCH REFERENCES

Am. Jur. 44 Am. Jur. 2d, Ins., § 727 et seq.

23-81-301. Title.

This subchapter shall be known as the "Standard Nonforfeiture Law for Individual Deferred Annuities".

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1.

23-81-302. Applicability.

This subchapter shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor

to any contract which shall be delivered outside this state through an agent or other representative of the insurer issuing the contract.

History. Acts 1981, No. 492, § 1; Revenue Code, referred to in this section, A.S.A. 1947, § 66-3327.1. is codified in 26 U.S.C. § 408.

U.S. Code. Section 408 of the Internal

23-81-303. Nonforfeiture requirements.

(a) In the case of contracts issued on or after the operative date of this subchapter as defined in § 23-81-312, no contract of annuity, except as stated in § 23-81-302, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions, which in the opinion of the Insurance Commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in §§ 23-81-305 — 23-81-308 and 23-81-310;

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in §§ 23-81-305, 23-81-306, 23-81-308, and 23-81-310. The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period of six (6) months after demand therefor with surrender of the contract;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits;

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract, or any prior withdrawals from or partial surrenders of the contract.

(b) Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid prior to the period would be less than twenty dollars (\$20.00) monthly, the insurer may at its option terminate the contract by payment in cash of the then-present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in

the contract for determining the paid-up annuity benefit, and by the payment shall be relieved of any further obligation under the contract.

History. Acts 1981, No. 492, § 1;
A.S.A. 1947, § 66-3327.1.

23-81-304. Minimum values.

(a) The minimum values as specified in §§ 23-81-305 — 23-81-308 and 23-81-310 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subchapter.

(b)(1)(A) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of one and one-half percent (1.5%) per annum of percentages of the net considerations paid prior to the time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of one and one-half percent (1.5%) per annum; and

(ii) The amount of any indebtedness to the insurer on the contract, including interest due and accrued and increased by any existing additional amounts credited by the insurer to the contract.

(B)(i) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero (0) and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars (\$30.00) and less a collection charge of one dollar and twenty-five cents (\$1.25) per consideration credited to the contract during that contract year.

(ii) The percentages of net considerations shall be sixty-five percent (65%) of the net consideration for the first contract year and eighty-seven and one-half percent (87.5%) of the net considerations for the second and later contract years.

(iii) Notwithstanding the provisions of subdivision (b)(1)(B)(ii) of this section, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year that exceeds by not more than two (2) multiplied by the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations that are paid annually, with two (2) exceptions:

(A) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent (65%) of the net consideration for the first contract year plus twenty-two and

one-half percent (22.5%) of the excess of the net considerations for the first contract year over the lesser of the net considerations for the second and third contract years; and

(B) The annual contract charge shall be the lesser of thirty dollars (\$30.00) or ten percent (10%) of the gross annual consideration.

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except, that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent (90%), and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars (\$75.00).

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1; Acts 2003, No. 669, § 1. substituted “one and one-half percent (1.5%)” for “three percent (3%)” in (b)(1)(A) and (b)(1)(A)(i).

Amendments. The 2003 amendment

23-81-305. Computation of present value.

(a) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.

(b) The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1.

23-81-306. Calculation of cash surrender values.

(a) For contracts which provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, the present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract.

(b) In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(c) The death benefit under the contracts shall be at least equal to the cash surrender benefit.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1.

23-81-307. Calculation of paid-up annuity benefits.

(a) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity. The present value shall be calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value and increased by any existing additional amounts credited by the insurer to the contract.

(b) For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(c) However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1.

23-81-308. Maturity date.

(a) For the purpose of determining the benefits calculated under §§ 23-81-306 and 23-81-307, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract. This date shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(b) This section does not apply to annuities funding funeral and related expenses.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1; Acts 2003, No. 669, § 2.

Amendments. The 2003 amendment redesignated the former section as present (a) and added (b).

23-81-309. Disclosure of limited death benefits.

Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

History. Acts 1981, No. 492, § 1;
A.S.A. 1947, § 66-3327.1.

23-81-310. Inclusion of lapse-of-time considerations.

Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

History. Acts 1981, No. 492, § 1;
A.S.A. 1947, § 66-3327.1.

23-81-311. Proration of values — Additional benefits.

(a) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits, if any, for the life insurance portion shall be computed as if each portion were a separate contract.

(b)(1) Notwithstanding the provisions of §§ 23-81-305 — 23-81-308 and 23-81-310, additional benefits payable:

(A) In the event of total and permanent disability;

(B) As reversionary annuity or deferred reversionary annuity benefits; or

(C) As other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all the additional benefits,

shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this subchapter.

(2) The inclusion of additional benefits shall not be required in any paid-up benefit, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

History. Acts 1981, No. 492, § 1;
A.S.A. 1947, § 66-3327.1.

23-81-312. Operative date.

(a) After June 17, 1981, any insurer may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this subchapter after a specified date before January 1, 1983.

(b) After the filing of the notice, then upon the specified date, which shall be the operative date of this subchapter for the insurer, this

subchapter shall become operative with respect to annuity contracts thereafter issued by the insurer.

(c) If an insurer makes no election, the operative date of this subchapter for the insurer shall be January 1, 1983.

History. Acts 1981, No. 492, § 1;
A.S.A. 1947, § 66-3327.1.

SUBCHAPTER 4 — VARIABLE CONTRACTS

SECTION.

23-81-401. Exceptions from Arkansas Insurance Code.

23-81-402. Provisions for allocation of income.

23-81-403. Contract provisions required.

SECTION.

23-81-404. Licensure requirements for delivery of contracts.

23-81-405. Insurance Commissioner's authority to regulate.

Effective Dates. Acts 1975, No. 728, § 8: Apr. 3, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1993, No. 901, § 52: Apr. 6, 1993.

Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present laws addressed in this omnibus Act on workers' compensation benefits and insurance licensure and other insurance regulatory issues are inadequate for the protection of the Arkansas public and immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this omnibus Act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

23-81-401. Exceptions from Arkansas Insurance Code.

(a) Except for §§ 23-81-122, 23-81-127, and 23-81-128 in the case of a variable annuity contract and §§ 23-81-104, 23-81-109 — 23-81-111, and 23-81-201 et seq. in the case of a variable life insurance policy and except for § 23-83-109 in the case of group variable life insurance, and except as otherwise provided in this subchapter, all pertinent provisions of the Arkansas Insurance Code shall apply to separate accounts and contracts relating thereto. Any group or individual variable life insurance contract or annuity contract delivered or issued for delivery in this state shall contain grace, reinstatement, and nonforfeiture provisions appropriate to the contract.

(b) The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guaranteed.

History. Acts 1975, No. 728, § 5; A.S.A. 1947, § 66-3341.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-81-402. Provisions for allocation of income.

A domestic life insurance company may establish one (1) or more separate accounts and may allocate thereto amounts including, without limitation, proceeds applied under optional modes of settlement or under dividend options to provide for life insurance or annuities, and benefits incidental thereto, payable in fixed or variable amounts, or subject to a market value adjustment as provided in rules and regulations adopted by the Insurance Commissioner, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account without regard to other income, gains, or losses of the company or to any other separate account of the company;

(2) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subdivision (3) of this section, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies. The investments in the separate accounts shall not be considered when applying the investment limitations otherwise applicable to the investments of the company;

(3) Except with the approval of the commissioner and under such conditions as to investments and other matters as the commissioner may prescribe which shall recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account;

(4)(A) Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, with the exception of separate accounts supporting modified guaranteed annuities which shall be valued as provided in such rules and regulations as the commissioner shall adopt, or, if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account.

(B) However, unless approved by the commissioner, the portion of any of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subdivision (3) of this section shall be valued in accordance with the rules otherwise applicable to the company's assets;

(5)(A) Amounts allocated to a separate account in the exercise of the power granted by this subchapter shall be owned by the company. The company shall not be, nor hold itself out to be, a trustee with respect to the amounts.

(B)(i) If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(ii) However, in no event shall the assets in a separate account for support of modified guaranteed annuity contracts subject to a market adjustment as provided in this section be immune from liabilities arising out of any other business the company conducts;

(6)(A) No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one (1) or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such a transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that the transfer of securities is approved by the commissioner.

(B) The commissioner may approve other transfers among accounts if, in the commissioner's opinion, the transfers would not be inequitable; and

(7) To the extent the company deems it necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including, without limitation, any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account.

History. Acts 1975, No. 728, § 1; A.S.A. 1947, § 66-3337; Acts 1993, No. 901, § 41.

23-81-403. Contract provisions required.

(a) Any contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of the variable benefits.

(b) Any contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that the dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

History. Acts 1975, No. 728, § 2;
A.S.A. 1947, § 66-3338.

23-81-404. Licensure requirements for delivery of contracts.

(a) No company shall deliver or issue for delivery within this state variable contracts unless it is licensed or organized to do a life insurance or annuity business in this state and unless the Insurance Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state.

(b)(1) In this connection, the commissioner shall consider among other things:

(A) The history and financial condition of the company;

(B) The character, responsibility, and fitness of the officers and directors of the company; and

(C) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts. The state of entry of an alien company shall be deemed its place of domicile for this purpose.

(2) If the company is a subsidiary of an admitted life insurance company or affiliated with such a company through common management or ownership, it may be deemed by the commissioner to have met the provisions of this section if either it or the parent or the affiliated company meets the requirements of this subsection.

History. Acts 1975, No. 728, § 3;
A.S.A. 1947, § 66-3339.

23-81-405. Insurance Commissioner's authority to regulate.

Notwithstanding any other provision of law, the Insurance Commissioner shall have sole authority to regulate the issuance and sale of variable contracts and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this subchapter.

History. Acts 1975, No. 728, § 4; A.S.A. 1947, § 66-3340; Acts 2001, No. 1382, § 4. **Amendments.** The 2001 amendment added "Insurance" in the section heading.

SUBCHAPTER 5 — VIATICAL SETTLEMENTS ACT

SECTION.

23-81-501 — 23-81-512. [Repealed.]

23-81-501 — 23-81-512. [Repealed.]

Publisher's Notes. This subchapter, concerning the Viatical Settlements Act, was repealed by Acts 2003, No. 1782, § 2. The subchapter was derived from the following sources:

23-81-501. Acts 1997, No. 490, § 1.
23-81-502. Acts 1997, No. 490, § 1;
2001, No. 1382, § 5.
23-81-503. Acts 1997, No. 490, § 1;
2001, No. 1604, § 115.

- 23-81-504. Acts 1997, No. 490, § 1.
 23-81-505. Acts 1997, No. 490, § 1.
 23-81-506. Acts 1997, No. 490, § 1.
 23-81-507. Acts 1997, No. 490, § 1.
 23-81-508. Acts 1997, No. 490, § 1;
 2001, No. 1382, § 6.
 23-81-509. Acts 1997, No. 490, § 1;
 2001, No. 1382, §§ 7, 8.
 23-81-510. Acts 1997, No. 490, § 1.
 23-81-511. Acts 1997, No. 490, § 1.

- 23-81-512. Acts 1997, No. 490, § 1.
 For present law, see § 23-81-601 et seq.
Effective Dates. Acts 1997, No. 490,
 § 1: applicable to all new viatical settle-
 ment contracts solicited, sold, issued, is-
 sued for delivery, or to be performed in
 this state on or after January 1, 1998.
 Acts 2003, No. 1782, § 2: repeal effective
 by its own terms on January 1, 2004.

SUBCHAPTER 6 — VIATICAL SETTLEMENTS ACT

SECTION.

- 23-81-601. Title.
 23-81-602. Definitions.
 23-81-603. License requirements.
 23-81-604. License revocation and denial.
 23-81-605. Approval of viatical settle-
 ment contracts and disclo-
 sure statements.
 23-81-606. Reporting requirements and
 privacy.
 23-81-607. Examination or investiga-
 tions.

SECTION.

- 23-81-608. Disclosure.
 23-81-609. General rules.
 23-81-610. Prohibited practices.
 23-81-611. Advertising for viatical settle-
 ments.
 23-81-612. Fraud prevention and control.
 23-81-613. Injunctions — Civil remedies
 — Cease and desist orders.
 23-81-614. Unfair trade practices.
 23-81-615. Authority to promulgate regu-
 lations.

Effective Dates. Acts 2003, No. 1782, §
 1: effective by its own terms on January 1,
 2004.

23-81-601. Title.

This subchapter may be cited as the “Viatical Settlements Act”.

History. Acts 2003, No. 1782, § 1.

23-81-602. Definitions.

As used in this subchapter:

(1)(A) “Advertising” means any written, electronic, or printed communication that is directly or indirectly published, disseminated, circulated, or placed before the public for the purpose of creating an interest in or inducing a person to sell a life insurance policy under a viatical settlement contract.

(B) “Advertising” includes any communication by means of film strip, motion picture, or video, and any message recorded by telephone or transmitted on radio, television, the Internet, or similar communications media;

(2) “Business of viatical settlements” means an activity involved in the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, trans-

ferring, assigning, pledging, hypothecating, or in any other manner of viatical settlement contracts or purchase agreements;

(3) "Chronically ill" means:

(A) Being unable to perform at least two (2) activities of daily living, such as eating, toileting, transferring, bathing, dressing, or continence;

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(C) Having a level of disability similar to that described in subdivision (3)(A) of this section, as determined by the Secretary of Health and Human Services;

(4)(A) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract:

(i) Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one (1) or more viaticated policies; and

(ii) Who has an agreement in writing with one (1) or more licensed viatical settlement providers to finance the acquisition of a viatical settlement contract.

(B) "Financing entity" does not include a nonaccredited investor or viatical settlement purchaser;

(5) "Fraudulent viatical settlement act" means:

(A) Acts or omissions committed by any person who, knowingly or with the intent to defraud and for the purpose of depriving another of property or for pecuniary gain, commits or permits its employees or its agents to engage in acts including:

(i) Presenting, causing to be presented, preparing, or concealing false material information with knowledge or belief that the information will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer, or any other person, as part of, in support of, or concerning a fact material to one (1) or more of the following:

(a) An application for the issuance of a viatical settlement contract or insurance policy;

(b) The underwriting of a viatical settlement contract or insurance policy;

(c) A claim for payment or benefit under a viatical settlement contract or insurance policy;

(d) Premiums paid on an insurance policy;

(e) Payments and changes in ownership or beneficiary made under the terms of a viatical settlement contract or insurance policy;

(f) The reinstatement or conversion of an insurance policy;

(g) The solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy;

(h) The issuance of written evidence of a viatical settlement contract or insurance policy; or

(i) A financing transaction; or

(ii) Employing any device, scheme, or artifice to defraud related to viaticated policies;

(B) In the furtherance of a fraud or to prevent the detection of a fraud, committing or permitting its employees or its agents to:

(i) Remove, conceal, alter, destroy, or sequester from the Insurance Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(ii) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(iv) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or that otherwise conceals information about a material fact from the commissioner;

(C) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policy owner, or any other person engaged in the business of viatical settlements or insurance;

(D)(i) Recklessly entering into, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, when the viator or the viator's agent intended to defraud the policy's issuer.

(ii) For purposes of this subdivision (5)(D), "recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, the disregard of which involves a gross deviation from acceptable standards of conduct; or

(E) Attempting to commit, assisting, aiding, or abetting in the commission of or conspiracy to commit the acts or omissions specified in this subdivision (5);

(6) "Person" means a natural person or a legal entity including an individual, partnership, limited liability company, association, trust, or corporation;

(7) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state;

(8)(A) "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing

entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction.

(B) The trust shall have a written agreement with the licensed viatical settlement provider under which:

(i) The provider is responsible for ensuring compliance with all statutory and regulatory requirements; and

(ii) The trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider;

(9) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either direct or indirect access to institutional capital markets for a financing entity or licensed viatical settlement provider;

(10) "Terminally ill" means having an illness or sickness that is reasonably expected to result in death in twenty-four (24) months or less;

(11)(A) "Viatical settlement broker" means a person that on behalf of a viator and for a fee, commission, or other valuable consideration offers or attempts to negotiate viatical settlement contracts between a viator and one (1) or more viatical settlement providers.

(B) Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(C) "Viatical settlement broker" does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser;

(12)(A) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance.

(B) "Viatical settlement contract" includes a contract for a loan or other financing transaction with a viator under subdivision (12)(A) of this section, other than a loan by a life insurance company under the terms of the life insurance contract or a loan secured by the cash value of a policy.

(C) "Viatical settlement contract" includes an agreement with a viator to transfer ownership or change the beneficiary designation at a later date, regardless of the date that compensation is paid to the viator;

(13)(A) “Viatical settlement provider” means a person, other than a viator, that enters into or effectuates a viatical settlement contract.

(B) “Viatical settlement provider” does not include:

(i) A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

(ii) The issuer of a life insurance policy providing accelerated benefits under State Insurance Department Rule 60, “Accelerated Benefits In Life Insurance Policies”, and under the contract;

(iii) An authorized or eligible insurer that provides stop-loss coverage to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(iv) A natural person who enters into or effectuates no more than one (1) agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(v) A financing entity;

(vi) A special purpose entity;

(vii) A related provider trust;

(viii) A viatical settlement purchaser; or

(ix) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, who purchases a viaticated policy from a viatical settlement provider;

(14)(A) “Viatical settlement purchaser” means a person who, for the purpose of deriving an economic benefit:

(i) Gives a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy;

(ii) Owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract; or

(iii) Is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract.

(B) “Viatical settlement purchaser” does not include:

(i) A licensee under this subchapter;

(ii) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust;

(15) “Viaticated policy” means a life insurance policy or certificate that has been acquired by a viatical settlement provider under a viatical settlement contract; and

(16)(A) “Viator” means the owner of a life insurance policy or a certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract.

(B) “Viator” does not include:

(i) A licensee under this subchapter;

- (ii) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;
- (iii) A financing entity;
- (iv) A special purpose entity; or
- (v) A related provider trust.

History. Acts 2003, No. 1782, § 1.

U.S. Code. Regulation D, Rule 501 and Rule 144A of the Federal Securities Act of

1933, referred to in (a)(8)(C), are codified as 17 CFR 230.501(a), 15 U.S.C. § 77b nt and 17 CFR 230.144A(a), respectively.

23-81-603. License requirements.

(a)(1) A person who is not licensed by the State Insurance Department to sell life or disability policies in Arkansas shall not operate as a viatical settlement provider or viatical settlement broker unless the person obtains a license from the insurance commissioner of the state of residence of the viator.

(2)(A) If there is more than one (1) viator on a single policy and the viators are residents of different states, the viatical settlement shall be governed by the law of the state in which the viator having the largest percentage of ownership resides.

(B) If the viators hold equal ownership, the viatical settlement shall be governed by the law of the state of residence of one (1) viator agreed upon in writing by all viators.

(b) Application for a viatical settlement provider or viatical settlement broker license shall be made to the Insurance Commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by the fees specified in State Insurance Department Rule 57, "Insurance Department Administrative and Regulatory Fees".

(c)(1) Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fees specified in State Insurance Department Rule 57, "Insurance Department Administrative and Regulatory Fees".

(2) Failure to pay the fees by the renewal date results in expiration of the license.

(d)(1) The applicant shall provide information on forms required by the commissioner.

(2) The commissioner may, at any time, require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees.

(3) The commissioner may refuse to issue a license in the name of a legal entity if the commissioner is not satisfied that any officer, employee, stockholder, partner, or member who may materially influence the applicant's conduct meets the standards under this subchapter.

(e)(1) A license issued under this subchapter to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers or viatical settlement brokers.

(2) Each person under subdivision (e)(1) of this section who is licensed as a viatical settlement provider or viatical settlement broker shall be named in the application and any supplements to the application.

(f) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(1) If a viatical settlement provider, has provided a detailed plan of operation;

(2) Is competent and trustworthy and intends to act in good faith in the capacity required by the license for which the applicant has applied;

(3) Has a good business reputation and has had experience, training, or education to be qualified in the business for which the license is applied;

(4) If a legal entity, provides a certificate of good standing from the state of its domicile; and

(5) If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of § 23-81-612(g).

(g) The commissioner shall not issue a license to a nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

(h) Each viatical settlement provider or viatical settlement broker shall provide to the commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members, or designated employees within thirty (30) days of the change.

History. Acts 2003, No. 1782, § 1.

23-81-604. License revocation and denial.

(a) The Insurance Commissioner may suspend, revoke, or refuse to issue or renew the license of a viatical settlement provider or viatical settlement broker if the commissioner finds that:

(1) The applicant or licensee made a material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or key management personnel has pleaded guilty or nolo contendere to, or has been found guilty of, fraudulent or dishonest practices and is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(3) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(4) The licensee or any officer, partner, member, or key management personnel has pleaded guilty or nolo contendere to, or has been found

guilty of, a felony or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(5) The viatical settlement provider has entered into any viatical settlement contract that has not been approved under this subchapter;

(6) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract;

(7) The licensee no longer meets the requirements for initial licensure;

(8) The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to:

(A) A person other than a viatical settlement provider licensed in this state;

(B) A viatical settlement purchaser;

(C) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended;

(D) A financing entity;

(E) A special purpose entity; or

(F) A related provider trust; or

(9) The licensee or any officer, partner, member, or key management personnel has violated any provision of this subchapter.

(b) If the commissioner denies a license application or suspends, revokes, or refuses to renew the license of a viatical settlement provider or viatical settlement broker, the commissioner shall conduct a hearing under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 2003, No. 1782, § 1.

1933, referred to in (a)(8)(C), are codified

U.S. Code. Regulation D, Rule 501 and Rule 144A of the Federal Securities Act of

as 17 CFR 230.501(a), 15 U.S.C. § 77b nt and 17 CFR 230.144A(a), respectively.

23-81-605. Approval of viatical settlement contracts and disclosure statements.

(a) A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement form in this state unless the form has been filed with and approved by the Insurance Commissioner.

(b)(1) The commissioner shall refuse to approve a viatical settlement contract form or disclosure statement form if the commissioner determines that the form contains provisions that are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator.

(2) By rule or regulation, the commissioner may require the submission of advertising material related to the sale of viatical settlement contracts.

History. Acts 2003, No. 1782, § 1.

23-81-606. Reporting requirements and privacy.

(a) Each licensee shall file with the Insurance Commissioner on or before March 1 of each year an annual statement containing such information as the commissioner prescribes by regulation.

(b) Except as otherwise allowed or required by law, no viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity shall disclose to any other person an insured's identity as an insured, or the insured's financial or medical information, unless the disclosure:

(1) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider, and the viator and insured have provided prior written consent to the disclosure;

(2) Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency under § 23-81-612(c);

(3) Is a term of or condition to the transfer of a policy by one (1) viatical settlement provider to another viatical settlement provider;

(4) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(5) Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

(6) Is required to purchase stop-loss coverage.

History. Acts 2003, No. 1782, § 1.

23-81-607. Examination or investigations.

(a) **AUTHORITY, SCOPE, AND SCHEDULING OF EXAMINATIONS.**

(1) The Insurance Commissioner may conduct an examination under this subchapter of a licensee as often as the Insurance Commissioner in his or her sole discretion deems appropriate.

(2) For purposes of completing an examination of a licensee under this subchapter, the Insurance Commissioner may examine or investigate any person, or the business of any person if necessary or material, in the sole discretion of the Insurance Commissioner to complete the examination of the licensee.

(3) In lieu of an examination under this subchapter of any foreign or alien licensee licensed in this state, the Insurance Commissioner may accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

(b) **RECORD RETENTION REQUIREMENTS.**

(1) A person required to be licensed by this subchapter shall for five (5) years retain copies of any:

(A) Proposed, offered, or executed contract, purchase agreement, underwriting document, policy form, and application from the date of

the proposal, offer, or execution of the contract or purchase agreement, whichever is later;

(B) Check, draft, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and

(C) Any other record and documents related to the requirements of this subchapter.

(2) This section does not relieve a person of the obligation to produce these documents to the Insurance Commissioner after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

(c) CONDUCT OF EXAMINATIONS.

(1)(A) Upon determining that an examination should be conducted, the Insurance Commissioner shall issue an examination warrant appointing one (1) or more examiners to perform the examination and instructing them as to the scope of the examination.

(B) In conducting the examination, the examiner shall observe those guidelines and procedures in the Examiners' Handbook adopted by the National Association of Insurance Commissioners.

(C) The Insurance Commissioner may also employ other guidelines or procedures as he or she may deem appropriate.

(2)(A) Each licensee or person from whom information is sought, its officers, directors, and agents, shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined.

(B) The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination to the extent that it is within their power to do so.

(C) The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Insurance Commissioner shall be grounds for suspension, refusal, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the Insurance Commissioner's jurisdiction.

(D) Any proceedings for the suspension, revocation, or refusal to issue or renew any license or authority shall be conducted under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(3)(A) The Insurance Commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination.

(B) Upon the failure or refusal of a person to obey a subpoena, the Insurance Commissioner may petition a court of competent jurisdiction

tion, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

(C) The failure to obey the court order shall be punishable as contempt of court.

(4) When making an examination under this subchapter, the Insurance Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be paid by the licensee that is the subject of the examination.

(5)(A) This subchapter does not limit the Insurance Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action under the insurance laws of this state.

(B) Findings of fact and conclusions made as the result of any examination shall be prima facie evidence in any legal or regulatory action.

(6) This subchapter does not limit the Insurance Commissioner's authority to use or to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the Insurance Commissioner may deem appropriate.

(d) EXAMINATION REPORTS.

(1) Examination reports shall be composed of only facts appearing upon the books, records, or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and those conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2)(A) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Insurance Commissioner a verified written report of examination under oath.

(B) Upon receipt of the verified report, the Insurance Commissioner shall transmit the report to the examinee, with a notice affording the examinee a reasonable opportunity of not more than thirty (30) days from the date the Insurance Commissioner causes the report to be transmitted to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) If the Insurance Commissioner determines that regulatory action is appropriate as a result of an examination, he or she may initiate any proceedings or actions provided by law.

(e) CONFIDENTIALITY OF EXAMINATION INFORMATION.

(1) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the Insurance Commissioner unless required by law.

(2)(A)(i) Except as otherwise provided in this subchapter or by the law of another state or jurisdiction that is substantially similar to

this subchapter, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Insurance Commissioner or any other person in the course of an examination made under this subchapter, or in the course of analysis or investigation by the Insurance Commissioner of the financial condition or market conduct of a licensee, shall be confidential and privileged.

(ii) Information under subdivision (e)(2)(A)(i) of this section shall not be subject to disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., or §§ 25-15-201 — 25-15-209 of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(B) The Insurance Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of his or her official duties.

(3) Documents, materials, or other information, including all working papers and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

(A) Created, produced, or obtained by or disclosed to the association and its affiliates or subsidiaries in the course of assisting an examination made under this subchapter, or assisting a commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(B) Disclosed to the association and its affiliates or subsidiaries under subdivision (e)(4) of this section by a commissioner.

(4) Neither the Insurance Commissioner nor any person that received the documents, material, or other information under this section while acting under the authority of the Insurance Commissioner, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision (e)(1) of this section.

(5) In order to assist in the performance of the Insurance Commissioner's duties, the Insurance Commissioner:

(A) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subdivision (e)(1) of this section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, if the recipient of the information agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(B)(i) May receive documents, materials, communications, or information, including otherwise confidential and privileged docu-

ments, materials, or information from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions.

(ii) The Insurance Commissioner shall maintain as confidential or privileged any document, material, or information received with notice or with the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(C) May enter into agreements governing the sharing and use of information consistent with this subsection.

(6) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Insurance Commissioner under this section or as a result of sharing as authorized in subdivision (e)(4) of this section.

(7) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(8) This subchapter does not prohibit the Insurance Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the National Association of Insurance Commissioners, if the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this subchapter.

(f) CONFLICT OF INTEREST.

(1)(A) An examiner may not be appointed by the Insurance Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this subchapter.

(B) However, this section does not automatically preclude an examiner from being:

(i) A viator;

(ii) An insured in a viaticated insurance policy; or

(iii) A beneficiary in an insurance policy that is proposed to be viaticated.

(2) Notwithstanding subdivision (f)(1) of this section, the Insurance Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this subchapter.

(g) COST OF EXAMINATIONS. Each person or organization examined under this subchapter shall pay to the State Insurance Department those expenses and costs authorized under § 23-61-206.

(h) IMMUNITY FROM LIABILITY.

(1) No cause of action shall arise nor shall any liability be imposed against the Insurance Commissioner, the Insurance Commissioner's authorized representative, or any examiner appointed by the Insurance Commissioner for any statement made or conduct performed in good faith while implementing this subchapter.

(2)(A) No cause of action shall arise nor shall any liability be imposed against any person for communicating or delivering information or data to the Insurance Commissioner or the Insurance Commissioner's authorized representative, or appointed examiner under an examination made under this subchapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(B) This subdivision (h)(2) does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (h)(1) or (h)(2)(A) of this section.

(3)(A) A person identified in subdivision (h)(1) or (2) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of the implementation of this subchapter and the party bringing the action was not substantially justified in doing so.

(B) For purposes of this subdivision (h)(3), a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(i) INVESTIGATIVE AUTHORITY OF THE COMMISSIONER. The Insurance Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

History. Acts 2003, No. 1782, § 1.

23-81-608. Disclosure.

(a)(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with a minimum of the disclosures under subdivision (a)(2) of this section no later than the time the application for the viatical settlement contract is signed by all parties.

(2) The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker and shall inform the viator that:

(A) There are possible alternatives to viatical settlement contracts, including any accelerated death benefits or policy loans offered under the viator's life insurance policy;

(B) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and that the viator should seek assistance from a professional tax advisor;

(C) Proceeds of the viatical settlement could be subject to the claims of creditors;

(D) Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements and that the viator should obtain advice from the appropriate government agencies;

(E)(i) The viator has the right to rescind a viatical settlement contract for fifteen (15) calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in § 23-81-609(c).

(ii) If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or purchaser;

(F) Funds will be sent to the viator within three (3) business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated;

(G) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that the viator should seek assistance from a financial adviser;

(H)(i) Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements.

(ii) The National Association of Insurance Commissioners' form for the brochure shall be used unless one is developed by the Insurance Commissioner;

(I) The disclosure document shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."; and

(J)(i) The insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status.

(ii) This contact is limited to one (1) time every three (3) months if the insured has a life expectancy of greater than one (1) year, and no more than one (1) time per month if the insured has a life expectancy of one (1) year or less.

(b)(1) A viatical settlement provider shall provide the viator with a minimum of the disclosures in subdivision (b)(2) of this section no later than the date the viatical settlement contract is signed by all parties.

(2) The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker and shall provide the following information:

(A) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

(B) The name, address, and telephone number of the viatical settlement provider;

(C) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

(D)(i) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate.

(ii) If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits; and

(E) The name, business address, and telephone number of the independent third party escrow agent and the fact that the viator or owner may inspect or receive copies of the relevant escrow, trust agreements, or documents.

(c) If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within twenty (20) days after the change.

History. Acts 2003, No. 1782, § 1.

23-81-609. General rules.

(a)(1) If the viator is the insured, a viatical settlement provider entering into a viatical settlement contract shall first obtain:

(A) A written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(B) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider, viatical settlement broker, and the insurance company that issued the life insurance policy covering the life of the insured.

(2)(A) Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise, or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the

insurer that issued that insurance policy that the policy has or will become a viaticated policy.

(B) The notice shall be accompanied by the documents required by subdivision (a)(3) of this section.

(3)(A) The viatical provider shall deliver a copy of the medical release required under subdivision (a)(1)(B) of this section, a copy of the viator's application for the viatical settlement contract, the notice required under subdivision (a)(2) of this section, and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction.

(B) The National Association of Insurance Commissioners' form for verification shall be used unless the Insurance Commissioner adopts different standards for verification.

(4) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(5)(A) No later than the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator:

- (i) Consents to the viatical settlement contract;
- (ii) Represents that he or she has a complete understanding of the viatical settlement contract;
- (iii) Represents that he or she has a complete understanding of the benefits of the life insurance policy; and
- (iv) Acknowledges that he or she is entering into the viatical settlement contract freely and voluntarily.

(B) If the insured has a terminal or chronic illness or condition, in addition to obtaining the information required under subdivision (5)(A) of this section, the viatical settlement provider shall obtain a witnessed document in which the viator acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(6) If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(b) Any medical information solicited or obtained by a licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

(c)(1) All viatical settlement contracts entered into in this state shall provide the viator with an unconditional right to rescind the contract for at least fifteen (15) calendar days from the receipt of the viatical settlement proceeds.

(2) If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to

repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser.

(d)(1) The viatical settlement provider shall instruct the viator to send the executed documents required to effect a change in ownership, assignment, or change in beneficiary directly to the independent escrow agent.

(2)(A) Within three (3) business days after the date the escrow agent receives the document, or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation.

(B) Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or to the related provider trust.

(C) Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or change in designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(e) Failure to tender consideration to the viator for the viatical settlement contract within the time specified under § 23-81-608(a)(2)(F) renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

(f)(1) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred:

(A) Shall only be made by the viatical settlement provider or broker licensed in this state or by its authorized representatives; and

(B) Shall be limited to one (1) time every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than one (1) time per month for insureds with a life expectancy of one (1) year or less.

(2) The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into.

(3) The limitations in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status.

(4) Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

History. Acts 2003, No. 1782, § 1.

23-81-610. Prohibited practices.

(a) It is a violation of this subchapter for any person to enter into a viatical settlement contract within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider that one (1) or more of the following conditions have been met within the two-year period:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy if the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four (24) months.

(2) The time covered under a group policy shall be calculated without regard to any change in insurance carriers if the coverage has been continuous and under the same group sponsorship;

(3) The viator is a charitable organization exempt from taxation under 26 U.S.C. § 501 (c)(3);

(4) The viator is not a natural person, but is a corporation, limited liability company, partnership, or similar entity;

(5) The viator submits independent evidence to the viatical settlement provider that one (1) or more of the following conditions have been met within the two-year period:

(A) The viator or insured is terminally or chronically ill;

(B) The viator's spouse dies;

(C) The viator divorces his or her spouse;

(D) The viator retires from full-time employment;

(E) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

(F) The viator was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;

(G) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets;

(H) The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or

(I) The viator or insured disposes of his or her ownership interests in a closely held corporation.

(b)(1) Copies of the independent evidence described in subdivision (a)(5) of this section and documents required by § 23-81-609(a) shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage.

(2) The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(c) If the viatical settlement provider submits to the insurer a copy of the owner's or insured's certification described in subdivision (a)(5) of

this section when the provider submits a request to the insurer to transfer the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section, and the insurer shall timely respond to the request.

History. Acts 2003, No. 1782, § 1.

23-81-611. Advertising for viatical settlements.

(a)(1) This section shall apply to any advertising of viatical settlement contracts, or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state.

(2) When disclosure requirements are established under federal law or regulation, this section shall be interpreted to minimize or eliminate the conflict whenever possible.

(b)(1)(A) Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services.

(B) A system of control shall include regular routine notification, at least one (1) time a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

(2) All advertisements under this subchapter, regardless of by whom they were written, created, designed, or presented, shall be the responsibility of the viatical settlement licensee as well as the individual who created or presented the advertisement.

(c)(1) Advertisements shall be truthful and shall not mislead in fact or by implication.

(2) The form and content of an advertisement of a viatical settlement contract shall be sufficiently complete and clear so as to avoid deception.

(3)(A) The advertisement shall not have the capacity or tendency to mislead or deceive.

(B) Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Insurance Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(d)(1) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(2)(A) An advertisement shall not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or

deceiving viators as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax effect.

(B) The fact that the viatical settlement contract offered is made available for inspection before consummation of the sale or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract includes a "free look" period that satisfies or exceeds legal requirements does not remedy misleading statements.

(3) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(4) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or is in any manner an incorrect or improper practice.

(5)(A) The words "free", "no cost", "without cost", "no additional cost", "at no extra cost", or words of similar import shall not be used with respect to any benefit or service unless true.

(B) An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(6)(A) Testimonials, appraisals, or analysis used in advertisements shall be genuine, shall represent the current opinion of the author, shall be applicable to any viatical settlement contract product or service advertised, and shall be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of the testimonials, appraisals, analysis, or endorsement.

(B) In using testimonials, appraisals, or analysis, the viatical settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(C) If the individual making a testimonial, appraisal, analysis, or an endorsement has a financial interest in the viatical settlement provider or related entity as a stockholder, director, officer, employee, or otherwise or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(D)(i) An advertisement shall not state or imply that a viatical settlement contract benefit or service has been approved or endorsed by a group of individuals, society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed.

(ii) If the entity making the endorsement or testimonial is owned, controlled, or managed by the viatical settlement licensee or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(E) When an endorsement refers to benefits received under a viatical settlement contract, all pertinent information shall be re-

tained by the viatical settlement licensee for a period of five (5) years after its use.

(e)(1) An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts.

(2) The source of all statistics used in an advertisement shall be identified.

(f) An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, insurance producers, policies, services, or methods of marketing.

(g)(1) The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract, products, or services, and if any specific viatical settlement contract is advertised, the viatical settlement contract shall be identified either by form number or some other appropriate description.

(2) If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

(h) An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the viatical settlement licensee if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract.

(i) An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise would tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

(j)(1) An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears if it does not exaggerate that fact or suggest or imply that competing viatical settlement licensees may not be so licensed.

(2) The advertisement may request the audience to consult the licensee's website or contact the department of insurance for the licensee's state to find out if the state requires licensing and, if so, whether the viatical settlement provider or viatical settlement broker is licensed.

(k) An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts are recommended or endorsed by any government entity.

(l)(1) The name of the actual licensee shall be stated in all of its advertisements.

(2) An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol, or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(m) An advertisement shall not directly or indirectly create the impression that any division or agency of the State of Arkansas or of the United States Government endorses, approves, or favors:

(1) Any viatical settlement licensee or its business practices or methods of operation;

(2) The merits, desirability, or advisability of any viatical settlement contract;

(3) Any viatical settlement contract; or

(4) Any life insurance policy or life insurance company.

(n) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(o) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six (6) months.

History. Acts 2003, No. 1782, § 1.

23-81-612. Fraud prevention and control.

(a) **FRAUDULENT VIACIAL SETTLEMENT ACTS — INTERFERENCE AND PARTICIPATION OF FELONS PROHIBITED.**

(1) A person shall not commit a fraudulent viatical settlement act.

(2) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this subchapter or an investigation of suspected or actual violations of this subchapter.

(3) A person in the business of viatical settlements shall not knowingly or intentionally permit any person to participate in the business of viatical settlements who has pleaded guilty or nolo contendere to, or has been found guilty of, a felony involving dishonesty or breach of trust.

(b) **FRAUD WARNING REQUIRED.**

(1) Viatical settlement contracts and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

“Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.”

(2) The failure to include the statement under subdivision (b)(1) of this section does not constitute a defense in a prosecution for a fraudulent viatical settlement act.

(c) MANDATORY REPORTING OF FRAUDULENT VIATICAL SETTLEMENT ACTS.

(1) Any person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the Insurance Commissioner the information required by, and in a manner prescribed by, the commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(d) IMMUNITY FROM LIABILITY.

(1) No civil liability shall be imposed on and no cause of action shall arise from a person furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts if the information is provided to or received from:

(A) The commissioner or the commissioner's employees, agents, or representatives;

(B) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(C) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees, or representatives;

(D) The National Association of Insurance Commissioners, the National Association of Securities Dealers, the North American Securities Administrators Association, or their employees, agents, or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud; or

(E) The life insurer that issued the life insurance policy covering the life of the insured.

(2)(A) Subdivision (d)(1) of this section shall not apply to statements made with actual malice.

(B) In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act or a fraudulent insurance act, the party bringing the action shall specifically plead any allegation that subdivision (d)(1) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(3)(A) A person identified in subdivision (d)(1) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in implementing this subchapter and the party bringing the action was not substantially justified in doing so.

(B) For purposes of this subdivision (d)(3), a proceeding is “substantially justified” if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subdivision (d)(1) of this section.

(e) CONFIDENTIALITY.

(1) The documents and evidence provided under subsection (d) of this section or obtained by the commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Subdivision (e)(1) of this section does not prohibit the release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(A) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(B) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the National Association of Insurance Commissioners; or

(C) At the discretion of the commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(3) Release of documents and evidence under subdivision (e)(2) of this section does not abrogate or modify the privilege granted in subdivision (e)(1) of this section.

(f) OTHER LAW ENFORCEMENT OR REGULATORY AUTHORITY.

This subchapter does not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from voluntarily disclosing information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the State Insurance Department; or

(3) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action.

(g) VIICAL SETTLEMENT ANTIFRAUD INITIATIVES.

(1)(A) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts.

(B) At the discretion of the commissioner, the commissioner may order, or a licensee may request and the commissioner may grant, modifications of the following required initiatives as necessary to ensure an effective antifraud program.

(C) The modifications may be more or less restrictive than the required initiatives under subdivision (g)(1) of this section if the

modifications may reasonably be expected to accomplish the purpose of this section.

(2) Antifraud initiatives shall include:

(A) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(B)(i) An antifraud plan, which shall be submitted to the commissioner.

(ii) The antifraud plan shall include, but not be limited to:

(a) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(3) Antifraud plans submitted to the commissioner shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action.

History. Acts 2003, No. 1782, § 1.

23-81-613. Injunctions — Civil remedies — Cease and desist orders.

(a) In addition to the penalties and other enforcement provisions of this subchapter, the Insurance Commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders to restrain the person from committing the violation.

(b) Any person damaged by the acts of a person violating this subchapter may bring a civil action in a court of competent jurisdiction against the person committing the violation.

(c) In accordance with §§ 23-66-209 — 23-66-213 of the Trade Practices Act, § 23-66-201 et seq., the commissioner may issue a cease and desist order upon a person that violates any provision of this subchapter, any regulation or order adopted by the commissioner under this subchapter, or any written agreement entered into with the commissioner under this subchapter.

(d)(1) When the commissioner finds that an activity in violation of this subchapter presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings.

(2) The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety (90) days.

(3) If the commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent a countermanding order by a court of competent jurisdiction under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(e)(1) In addition to the penalties and other enforcement provisions of this subchapter, any person who violates this subchapter is subject to civil penalties under § 23-66-210.

(2) The commissioner shall impose civil penalties by order under §§ 23-66-209 — 23-66-213 of the Trade Practices Act, § 23-66-201 et seq.

(3) The commissioner's order may require a person found to be in violation of this subchapter to make restitution to persons aggrieved by violations of this subchapter.

(f)(1) A person who is found guilty of, or pleads guilty or nolo contendere to, a violation of this subchapter shall be guilty of a Class D felony.

(2) A person who is found guilty of, or pleads guilty or nolo contendere to, a fraudulent viatical settlement act shall be ordered to pay restitution to persons aggrieved by the violation of the fraudulent viatical settlement act.

(3) Restitution may be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

History. Acts 2003, No. 1782, § 1.

23-81-614. Unfair trade practices.

A violation of this subchapter shall be considered an unfair trade practice under §§ 23-66-209 — 23-66-213 of the Trade Practices Act, § 23-66-201 et seq., and shall be subject to the penalties contained therein.

History. Acts 2003, No. 1782, § 1.

23-81-615. Authority to promulgate regulations.

The Insurance Commissioner may:

(1) Promulgate regulations implementing this subchapter;

(2)(A) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill.

(B) This authority includes the regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy;

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and viatical settlement brokers;

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

(5) Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers and viatical settlement brokers during the viatication of a life insurance policy or certificate.

History. Acts 2003, No. 1782, § 1.

CHAPTER 82

INDUSTRIAL LIFE INSURANCE

SECTION.

23-82-101. Definition.

23-82-102. Scope.

23-82-103. Application to term and specified insurance.

23-82-104. Policies prohibited.

23-82-105. Grace period provision.

23-82-106. Integrity of contract and application provision.

23-82-107. Incontestability provision.

23-82-108. Misstatement of age provision.

23-82-109. Dividend provision.

23-82-110. Nonforfeiture benefits and cash surrender value provisions.

SECTION.

23-82-111. Reinstatement provision.

23-82-112. Settlement provision.

23-82-113. Authority to alter contract provision.

23-82-114. Designation of beneficiary — Payment upon insured's death.

23-82-115. Direct payment of premiums provision.

23-82-116. Conversion provision.

23-82-117. Title required.

23-82-118. Prohibited provisions.

Cross References. Manner of payment of claims, § 23-63-107.

23-82-101. Definition.

For the purpose of this code, unless the context otherwise requires, "industrial life insurance" is that form of life insurance written under policies of face amount of two thousand dollars (\$2,000) or less bearing the words "industrial policy" imprinted on the face thereof as part of the descriptive matter and under which premiums are payable monthly or more often.

History. Acts 1959, No. 148, § 347; A.S.A. 1947, § 66-3402. No. 148, codified as set out in the note following § 23-74-306.

Meaning of "this code". Acts 1959,

23-82-102. Scope.

The provisions of this chapter apply only to industrial life insurance policies. The following sections shall also apply to industrial life insurance:

(1) Section 23-81-114, excluded or restricted coverage;

- (2) Section 23-81-115, limitation of liability;
- (3) Section 23-81-129, incontestability after reinstatement;
- (4) Section 23-81-120, prohibited policy plans; and
- (5) Section 23-81-201, standard nonforfeiture law.

History. Acts 1959, No. 148, § 346;
A.S.A. 1947, § 66-3401.

23-82-103. Application to term and specified insurance.

Any of the provisions required by §§ 23-82-105 — 23-82-117 or any portion thereof which are not applicable to single premium or term policies or to policies issued or granted pursuant to nonforfeiture provisions shall to that extent not be incorporated therein.

History. Acts 1959, No. 148, § 362;
A.S.A. 1947, § 66-3417.

23-82-104. Policies prohibited.

No policy of industrial life insurance shall be offered, delivered, or issued for delivery in this state on or after January 1, 1988.

History. Acts 1959, No. 148, § 348;
A.S.A. 1947, § 66-3403; Acts 1987, No.
351, § 1.

23-82-105. Grace period provision.

(a) There shall be a provision that the insured is entitled to a grace period of four (4) weeks within which the payment of any premiums after the first may be made, except that in policies for which the premiums are payable monthly, the period of grace shall be one (1) month, but not less than thirty (30) days.

(b) If during the grace period the policy becomes a claim, then any overdue and unpaid premiums may be deducted from any settlement under the policy.

History. Acts 1959, No. 148, § 349;
A.S.A. 1947, § 66-3404.

23-82-106. Integrity of contract and application provision.

(a) There shall be a provision that the policy shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the policy when issued, a provision that the policy and the application therefor shall constitute the entire contract.

(b) If the application is so made a part of the contract, the policy shall also provide that, in the absence of fraud, all statements made by the applicant in such an application shall be deemed to be representations and not warranties.

History. Acts 1959, No. 148, § 350;
A.S.A. 1947, § 66-3405.

23-82-107. Incontestability provision.

There shall be a provision that the policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

History. Acts 1959, No. 148, § 351;
A.S.A. 1947, § 66-3406.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-82-108. Misstatement of age provision.

(a) There shall be a provision that if it is found that the age of the individual insured or the age of any other individual considered in determining the premium has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have been had it been purchased stating the correct age.

(b) As to overstatement of age, the policy may provide, in lieu of the provision required under subsection (a) of this section, that the insurer will refund any excess of premium collected for the amount of insurance or benefit stated in the policy, as based upon the correct age.

History. Acts 1959, No. 148, § 352;
A.S.A. 1947, § 66-3407.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-82-109. Dividend provision.

(a) If the industrial life insurance policy is a participating policy, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy. However, at the option of the insurer, the participation may be deferred to the end of the fifth policy year.

(b) This provision shall not prohibit the payment of additional dividends on default of payment of premiums or termination of the policy.

History. Acts 1959, No. 148, § 353; A.S.A. 1947, § 66-3408; Acts 2001, No. 1553, § 51.

Amendments. The 2001 amendment inserted "the industrial life insurance policy" in (a).

23-82-110. Nonforfeiture benefits and cash surrender value provisions.

There shall be provisions for nonforfeiture benefits and cash surrender values as required by the Standard Nonforfeiture Law for Life Insurance, § 23-81-201 et seq.

History. Acts 1959, No. 148, § 354; A.S.A. 1947, § 66-3409.

23-82-111. Reinstatement provision.

There shall be a provision that unless the policy has been surrendered for its cash surrender value or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within two (2) years from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy, all with interest at a rate not exceeding six percent (6%) per annum, compounded annually.

History. Acts 1959, No. 148, § 355; A.S.A. 1947, § 66-3410.

23-82-112. Settlement provision.

There shall be a provision that when the policy becomes a claim by the death of the insured, settlement shall be made upon surrender of the policy and receipt of due proof of death.

History. Acts 1959, No. 148, § 356; A.S.A. 1947, § 66-3411.

23-82-113. Authority to alter contract provision.

There shall be a provision that no agent shall have the power or authority to waive, change, or alter any of the terms or conditions of any policy, except that at the option of the insurer, the terms or conditions may be changed by an endorsement or rider signed by an authorized officer of the insurer.

History. Acts 1959, No. 148, § 357; A.S.A. 1947, § 66-3412.

23-82-114. Designation of beneficiary — Payment upon insured's death.

(a) Each policy shall have a space for the name of the beneficiary designated with a reservation of the right to designate or change the beneficiary after the issuance of the policy.

(b)(1) The policy may also provide that no designation or change of beneficiary shall be binding on the insurer unless endorsed on the policy by the insurer and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured.

(2) The policy may provide that the insurer may make payment thereunder to the executor or administrator of the insured, or to any of the insured's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary or by reason of having incurred expense for the maintenance, medical attention, or burial of the insured if the beneficiary designated in the policy does not surrender the policy with due proof of death within the period stated in the policy, which shall be not less than thirty (30) days after the death of the insured, or if the beneficiary dies before the insured, or the beneficiary is the estate of the insured, a minor, or is not legally competent to give a valid release.

(3) The policy may also include a similar provision applicable to any other payment due under the policy.

History. Acts 1959, No. 148, § 358;
A.S.A. 1947, § 66-3413.

23-82-115. Direct payment of premiums provision.

In the case of weekly premium policies, there may be a provision that upon proper notice to the insurer, while premiums on the policy are not in default beyond the grace period, of the intention to pay future premiums directly to the insurer at its home office or any office designated by the insurer for that purpose, the insurer will, at the end of each period of a year from the due date of the first premium so paid, for which period the premiums are so paid continuously without default beyond the grace period, refund a stated percentage of the premiums in an amount which fairly represents the savings in collection expense.

History. Acts 1959, No. 148, § 359;
A.S.A. 1947, § 66-3414.

23-82-116. Conversion provision.

(a) There may be a provision in the case of industrial policies granting to the insured, upon proper written request and upon presentation of evidence of insurability satisfactory to the insurer, the privilege of converting any industrial insurance policy to any form of life insurance with less frequent premium payments regularly issued by

the insurer, in accordance with terms and conditions agreed upon with the insurer.

(b) The privilege of making the conversion need be granted only if the insurer's industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of the insurance with less frequent premium payments issued by the insurer at the age of the insured on the plan of industrial or ordinary insurance desired.

History. Acts 1959, No. 148, § 360;
A.S.A. 1947, § 66-3415.

23-82-117. Title required.

There shall be a title on the face of each policy briefly describing its form.

History. Acts 1959, No. 148, § 361;
A.S.A. 1947, § 66-3416.

23-82-118. Prohibited provisions.

No policy of industrial life insurance shall contain any of the following provisions:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer;

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical, or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within two (2) years prior to the issuance of the policy, received institutional, hospital, medical, or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning the treatment or attention was not of a serious nature or was not material to the risk; or

(3) A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless the right is conditioned upon a showing by the insurer that knowledge of the rejection would have led to a refusal by the insurer to make the contract.

History. Acts 1959, No. 148, § 363;
A.S.A. 1947, § 66-3418.

CHAPTER 83

GROUP LIFE INSURANCE AND ANNUITIES

SECTION.

- 23-83-101. Group contracts must meet group requirements.
- 23-83-102. Employee groups.
- 23-83-103. Labor union groups.
- 23-83-104. Trustee groups.
- 23-83-105. Debtor groups and credit union groups.
- 23-83-106. Association groups.
- 23-83-107. Restrictions on coverage of other groups.
- 23-83-108. Restrictions on coverage of spouse and dependent children of group member.
- 23-83-109. Provisions required in policy.
- 23-83-110. Grace period for payment of premium provision.
- 23-83-111. Incontestability provision.
- 23-83-112. Application attached to policy provision — Statements deemed representations.
- 23-83-113. Insurability provision.
- 23-83-114. Misstatement of age provision.
- 23-83-115. Payment of benefits provision.
- 23-83-116. Issuance of certificate to policyholder provision.

SECTION.

- 23-83-117. Conversion on termination of eligibility provision.
- 23-83-118. Conversion on termination of policy provision.
- 23-83-119. Death pending conversion provision.
- 23-83-120. Continuation of coverage during insured's total disability provision.
- 23-83-121. Delivery of certificate of insurance to insured debtors provision.
- 23-83-122. Notice as to conversion right.
- 23-83-123. Group insurance on Arkansas residents placed in authorized insurers.
- 23-83-124. Group insurance in unauthorized insurer.
- 23-83-125. Assignment of rights or incidents of ownership.
- 23-83-126. Assignment of rights not to prejudice insurer.
- 23-83-127. [Repealed.]

Cross References. Manner of payment of claims, § 23-63-107.

RESEARCH REFERENCES

ALR. Binding effect of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds. 6 ALR 4th 835.

Liability of employer to employee in connection with selection or retention of group insurer. 10 ALR 4th 1267.

Termination for employee's individual coverage under group policy, nonpayment of premiums. 22 ALR 4th 321.

Conversion privilege of employee re-

garding insurance after termination of employment. 32 ALR 4th 1037.

Credit life insurer's punitive damage liability for refusing liability. 55 ALR 4th 246.

What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy. 86 ALR 4th 886.

Am. Jur. 44A Am. Jur. 2d, Ins., §§ 1829, 1837, 1838, 1862, 1863.

23-83-101. Group contracts must meet group requirements.

(a) Except when specifically provided otherwise, "policy" as used in this chapter shall include both life insurance and annuities.

(b)(1) No policy shall be delivered in this state insuring the lives of more than one (1) individual with or without one (1) or more members of the family or one (1) or more dependents, or covering one (1) or more members of the family or one (1) or more dependents of the group of persons, unless to one (1) of the groups as provided for in §§ 23-83-102 — 23-83-107 and unless in compliance with the other applicable provisions of this chapter.

(2) Subdivision (b)(1) of this section shall not apply to policies:

(A) Insuring only individuals related by blood, marriage, or legal adoption;

(B) Insuring only individuals having a common interest through ownership of a business enterprise, or a substantial legal interest or equity therein, and who are actively engaged in the management thereof; or

(C) Insuring only individuals otherwise having an insurable interest in each other's lives.

History. Acts 1981, No. 898, § 1;
A.S.A. 1947, § 66-3501.

CASE NOTES

Business Enterprises.

A group insurance certificate issued to a director not otherwise employed by the corporate employer was void even though issued by the insurer with full knowledge

of the director's status and without misrepresentation by the director. *Gill v. General Am. Life Ins. Co.*, 434 F.2d 1057 (8th Cir. 1970) (decision under prior law).

23-83-102. Employee groups.

A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, shall be subject to the following requirements:

(1)(A) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any classes thereof.

(B) The policy may provide that the term "employees" shall include the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, or partnerships is under common control.

(C) The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership.

(D) The policy may provide that the term "employees" shall include retired employees and directors of a corporate employer.

(E) A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing; and

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 2;
A.S.A. 1947, § 66-3502.

23-83-103. Labor union groups.

A policy issued to a labor union or similar employer organization, which shall be deemed to be the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all members of any classes thereof;

(2)(A) The premium for the policy shall be paid either from funds of the union or from funds contributed by the insured members specifically for their insurance, or from insurance, or from both.

(B) Except as provided in subdivision (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing; and

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 3;
A.S.A. 1947, § 66-3503.

23-83-104. Trustee groups.

A policy issued to a trust or to the trustee of a fund established by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1)(A) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any classes thereof.

(B) The policy may provide that the term “employees” shall include:

(i) Retired employees, the individual proprietor or partners if an employer is an individual proprietorship or a partnership, and directors of a corporate employer; and

(ii) The trustees or their employees, or both, if their duties are principally connected with such a trusteeship;

(2)(A) The premium for the policy shall be paid from funds contributed by the employer of the insured persons or by the union or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization.

(B) Except as provided in subdivision (3) of this section, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing; and

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 4;
A.S.A. 1947, § 66-3504.

CASE NOTES

Eligibility.

The fact that an insurer issued a group policy certificate to a nonemployee director of a corporation, with the exact status of such director fully disclosed in his application, that there was no fraud or deception of any kind, and that the insurer

accepted premiums on the certificate until the death of the director, did not validate the certificate nor estop the insurer from defending on the ground of the director's ineligibility for such insurance. *Gill v. General Am. Life Ins. Co.*, 434 F.2d 1057 (8th Cir. 1970) (decision under prior law).

23-83-105. Debtor groups and credit union groups.

(a) Excluding an annuity policy, a policy issued to a creditor or its parent holding company or to a trustee or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee, or agent shall be deemed the policyholder, to insure debtors of the creditor, or creditors, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor, or all of any classes thereof. The policy may provide that the term “debtor” shall include:

(A) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(B) The debtors of one (1) or more subsidiary corporations; and

(C) The debtors of one (1) or more affiliated corporations, proprietorships, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, or partnerships is under common control;

(2)(A) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both.

(B) Except as provided in subdivision (a)(3) of this section, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(3) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer;

(4) The amount of the insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor;

(5) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment; and

(6) Notwithstanding the provisions of subdivisions (a)(1)-(5) of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(b) Excluding an annuity policy, a policy issued to a credit union or to a trustee or agent designated by two (2) or more credit unions, which credit union, trustee, or agent shall be deemed the policyholder, to insure members of the credit union or for the benefit of persons other than the credit union, trustee, or agent or any of their officials, subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or all members of any classes thereof;

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision (b)(3) of this section, must insure all eligible members; and

(3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 5;
A.S.A. 1947, § 66-3505.

23-83-106. Association groups.

(a) A policy can be issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations.

- (b) The association shall have:
 - (1) At the outset a minimum of one hundred (100) persons;
 - (2) Been organized and maintained in good faith for purposes other than that of obtaining insurance;
 - (3) Been in active existence for at least two (2) years; and
 - (4) A constitution and bylaws which provide that:
 - (A) The association hold regular meetings not less than annually to further purposes of members;
 - (B) Except for credit unions, the association collect dues or solicit contributions from members; and
 - (C) The members have voting privileges and representation on the governing board and committees.
- (c) The policy shall be subject to the following requirements:
 - (1) The policy may insure members of the association, employees thereof, or employees of members, or one (1) or more of the preceding or all of any classes thereof for the benefit of persons other than the employee's employer;
 - (2) The premium for the policy shall be paid from funds contributed by the association or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association or employer members;
 - (3) Except as provided in subdivision (c)(5) of this section, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing;
 - (4) The Insurance Commissioner may issue regulations setting forth the disclosure requirements if a part or all of the premium for a policy issued under this section is derived from funds contributed by the covered persons for their insurance and if any compensation, including, but not limited to, dividends, premiums refunds, or retroactive rate adjustments, is received, directly or indirectly, by the policyholder, including participating associations of a trust; and
 - (5) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 6;
A.S.A. 1947, § 66-3506.

23-83-107. Restrictions on coverage of other groups.

Group insurance offered to a resident of this state under a group policy issued to a group other than one described in §§ 23-83-102 — 23-83-106 shall be subject to the following requirements:

- (1) No group policy or certificate shall be delivered in this state unless the Insurance Commissioner finds that:
 - (A) The issuance of the group policy is not contrary to the best interest of the public;
 - (B) The issuance of the group policy would be actuarially sound;

(C) The issuance of the group policy would result in economies of acquisition or administration; and

(D) The benefits are reasonable in relation to the premiums charged.

(2) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both;

(3) The commissioner may issue regulations implementing the requirements of subdivision (1) of this section; and

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 7; A.S.A. 1947, § 66-3507; Acts 1987, No. 254, § 1.

23-83-108. Restrictions on coverage of spouse and dependent children of group member.

Except for a policy issued under § 23-83-105(a), a group policy, excluding an annuity policy, may be extended to insure the employees or members against loss due to the death of their spouses and dependent children or any classes thereof, subject to the following:

(1)(A) The premium for the insurance shall be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both.

(B) Except as provided in subdivision (2) of this section, a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their spouses and dependent children or any class or classes thereof unless rejected in writing by the employee or member; and

(2) An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

History. Acts 1981, No. 898, § 8; A.S.A. 1947, § 66-3508; Acts 2001, No. 1382, § 9.

Amendments. The 2001 amendment added "unless rejected in writing by the employee or member; and" in (a); and deleted (3) and made related changes.

23-83-109. Provisions required in policy.

(a) No policy shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the Insurance Commissioner are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder.

(b) However:

(1) Provisions in §§ 23-83-115 — 23-83-119 shall not apply to policies insuring the lives of debtors;

(2) The standard provisions required for individual policies shall not apply to group policies; and

(3) If the group policy is an annuity policy or is a life insurance policy on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision which in the opinion of the commissioner is equitable to the insured persons and to the policyholder, but nothing in this subdivision (b)(3) shall be construed to require that group policies contain the same nonforfeiture provisions as are required for individual policies.

History. Acts 1981, No. 898, § 9;
A.S.A. 1947, § 66-3509.

CASE NOTES

Cited: *Dodson v. J.C. Penney Co.*, 336 F.3d 696 (8th Cir. 2003).

23-83-110. Grace period for payment of premium provision.

(a) Excluding an annuity policy, the group policy shall contain a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy.

(b) The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such a grace period.

History. Acts 1981, No. 898, § 10;
A.S.A. 1947, § 66-3510.

CASE NOTES

Notice.

Oral cancellation of life insurance policy by policyholder who died less than a month after the policy lapsed did not relieve insurer of its statutory duty to

provide a 31-day grace period once it lapsed. *Dodson v. J.C. Penney Co.*, 309 F.3d 476 (8th Cir. 2002), *aff'd*, 2003 U.S. App. LEXIS 14193, — F.3d — (8th Cir. July 15, 2003).

23-83-111. Incontestability provision.

(a) The group policy shall contain a provision that the validity of the policy shall not be contested, except for fraud in the procurement or nonpayment of premiums after it has been in force for two (2) years from its date of issue, and that no statement made by any person insured under the policy relating to the insured's insurability shall be used in contesting the validity of the insurance with respect to which

the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime unless it is contained in a written instrument signed by the insured. However, at its option, the insurer may omit from the provision the phrase "except for fraud in the procurement".

(b) However, no provision shall preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage.

History. Acts 1981, No. 898, § 11; A.S.A. 1947, § 66-3511; Acts 2001, No. 1382, § 10.

Amendments. The 2001 amendment,

in (a), inserted "fraud in the procurement or," added the last sentence, and made gender neutral changes and minor stylistic changes.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

CASE NOTES

Eligibility for Coverage.

Former similar section did not bar the defense to a group life policy that the insured was ineligible for the insurance because of belonging to a class prohibited

by statute from inclusion in the group. Gill v. General Am. Life Ins. Co., 434 F.2d 1057 (8th Cir. 1970) (decision under prior law.)

23-83-112. Application attached to policy provision — Statements deemed representations.

The group policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of death or incapacity of the insured person, to his or her beneficiary or personal representative.

History. Acts 1981, No. 898, § 12; A.S.A. 1947, § 66-3512.

23-83-113. Insurability provision.

The group policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage.

History. Acts 1981, No. 898, § 13;
A.S.A. 1947, § 66-3513.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-83-114. Misstatement of age provision.

A group policy shall contain a provision specifying an equitable adjustment of premiums or of benefits, or of both, to be made in the event the age of a person insured has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.

History. Acts 1981, No. 898, § 14;
A.S.A. 1947, § 66-3514.

23-83-115. Payment of benefits provision.

A group policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured. However, when the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, as to all or any part of such a sum, subject to the provisions of the policy in the event there is no designated beneficiary living at the death of the person insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding ten thousand dollars (\$10,000) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

History. Acts 1981, No. 898, § 15; substituted "ten thousand dollars A.S.A. 1947, § 66-3515; Acts 2001, No. (\$10,000)" for "two thousand dollars 1382, § 11. (\$2,000)."

Amendments. The 2001 amendment

23-83-116. Issuance of certificate to policyholder provision.

A group policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, as to any dependent's coverage included in such a certificate, and the rights and conditions set forth in §§ 23-83-117 — 23-83-120 and 23-83-122.

History. Acts 1981, No. 898, § 16;
A.S.A. 1947, § 66-3516.

23-83-117. Conversion on termination of eligibility provision.

Excluding an annuity policy, a group policy shall contain a provision that if the insurance or any portion of it on a person covered under the policy or on the dependent of a person covered ceases because of termination of employment or of membership in the classes eligible for coverage under the policy, the persons shall be entitled to have issued to them by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits. However, an application for the individual policy shall be made by the person covered under the policy or the dependent of the covered person and the first premium paid to the insurer within thirty-one (31) days after the termination, and in addition:

(1) At the option of the persons, the individual policy shall be on any one (1) of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

(2)(A) The individual policy shall be in an amount not in excess of the amount of life insurance that ceases because of the termination, less the amount of any life insurance for which the person becomes eligible under the same or any other group policy within thirty-one (31) days after the termination.

(B) However, any amount of insurance that shall have matured on or before the date of the termination as an endowment payable to the person insured, whether in one (1) sum or in installments or in the form of an annuity, shall not be included, for the purposes of this provision, in the amount that is considered to cease because of the termination;

(3) The premium on the individual policy shall be at the insurer's then-customary rate applicable to the form and amount of the individual policy, to the class of risk to which the person then belongs, and to his or her age attained on the effective date of the individual policy; and

(4) Subject to the same conditions set forth above, the conversion privilege shall be available:

(A) To a surviving covered dependent, if any, at the death of the covered person, with respect to the coverage under the group policy that terminates by reason of the death; and

(B) To the covered dependent of the person upon termination of coverage of the dependent, while the covered person remains insured under the group policy, by reason of the dependent's ceasing to be a qualified family member under the group policy.

History. Acts 1981, No. 898, § 17; A.S.A. 1947, § 66-3517; Acts 2001, No. 1382, § 12.

Amendments. The 2001 amendment inserted "by the person covered under the policy or the dependent of the covered person" in the introductory language; in (4)(A), inserted "covered" following "sur-

living" and substituted "covered person" for "employee or member"; in (4)(B), substituted "covered dependent of the person" for "dependent of the employee or member" and "covered person" for "employee or member"; and made minor stylistic changes throughout.

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992 Insurance Law Decisions, 1992 Ark. L. Notes 85.

Ark. L. Rev. Huff, The Irrevocable Life Insurance Trust, 38 Ark. L. Rev. 139.

CASE NOTES

ANALYSIS

Conditions precedent.
Notice.

Conditions Precedent.

The right to convert a group policy to an individual policy is not an absolute right, and the insurance company may properly insist upon the strict performance by the insured of the conditions precedent contained in the conversion provision. *Butler v. MFA Life Ins. Co.*, 591 F.2d 448 (8th Cir. 1979) (decision under prior law).

Notice.

The right to convert a group policy to an

individual policy is a valuable contractual right of the discharged employee; thus to avoid the inadvertent loss of the conversion right, the insurer must give the discharged employee adequate written notice of the provision, and it must act on the insured's application for conversion in a reasonable and timely fashion. *Butler v. MFA Life Ins. Co.*, 591 F.2d 448 (8th Cir. 1979) (decision under prior law).

Cited: *Life Ins. Co. v. Ashley*, 308 Ark. 335, 824 S.W.2d 393 (1992).

23-83-118. Conversion on termination of policy provision.

(a) Excluding an annuity policy, a group policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of the termination whose insurance terminates, including the insured dependent of a covered person, and who has been an insured for at least five (5) years prior to the termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by § 23-83-117.

(b) However, the group policy may provide that the amount of the individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one (31) days after the termination; or

(2) Ten thousand dollars (\$10,000).

History. Acts 1981, No. 898, § 18;
A.S.A. 1947, § 66-3518.

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992

Insurance Law Decisions, 1992 Ark. L. Notes 85.

CASE NOTES

Cited: Life Ins. Co. v. Ashley, 308 Ark. 335, 824 S.W.2d 393 (1992).

23-83-119. Death pending conversion provision.

Excluding an annuity policy, a group policy shall contain a provision that if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual policy issued to him or her in accordance with §§ 23-83-117 and 23-83-118 and before the individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under the individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

History. Acts 1981, No. 898, § 19; A.S.A. 1947, § 66-3519.

RESEARCH REFERENCES

Ark. L. Notes. Copeland, A Brief Survey of Some Important 1991 and 1992 Insurance Law Decisions, 1992 Ark. L. Notes 85.

CASE NOTES

Cited: Life Ins. Co. v. Ashley, 308 Ark. 335, 824 S.W.2d 393 (1992).

23-83-120. Continuation of coverage during insured's total disability provision.

(a) Excluding an annuity policy, a group policy shall contain a provision that when active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred.

(b) The continuation shall be on a premium-paying basis for a period of six (6) months from the date on which the total disability started, but not beyond the earlier of approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain or the discontinuance of the group insurance policy.

History. Acts 1981, No. 898, § 20; A.S.A. 1947, § 66-3520.

23-83-121. Delivery of certificate of insurance to insured debtors provision.

In the case of a policy insuring the lives of debtors, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the death benefit shall first be applied to reduce or extinguish the indebtedness shall be included.

History. Acts 1981, No. 898, § 21; A.S.A. 1947, § 66-3521.

23-83-122. Notice as to conversion right.

(a) If any individual insured under a group policy, excluding an annuity policy, hereafter delivered in this state becomes entitled under the terms of the policy to have an individual policy of life insurance issued to him or her without evidence of insurability, subject to making of application and payment of the first premium by the individual within the period specified in the policy and if the individual is not given notice of the existence of the right at least fifteen (15) days prior to the expiration date of the period, then the individual shall have an additional period within which to exercise that right. Nothing in this subsection shall be construed to continue any insurance beyond the period provided in the policy.

(b) Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

History. Acts 1981, No. 898, § 22; A.S.A. 1947, § 66-3522; Acts 2001, No. 1382, § 13.

Amendments. The 2001 amendment,

in (a), inserted "by the individual" and "or her"; and deleted (b) and redesignated the remaining subsection accordingly.

CASE NOTES**ANALYSIS**

Conditions precedent.
Conversion period.
Improper notice.
Necessity of notice.

Conditions Precedent.

The right to convert a group policy to an individual policy is not an absolute right, and the insurance company may properly insist upon the strict performance by the insured of the conditions precedent contained in the conversion provision. *Butler v. MFA Life Ins. Co.*, 591 F.2d 448 (8th Cir. 1979) (decision under prior law).

Conversion Period.

By giving a person entitled to a conversion notice of that right, the insurance company can shorten the conversion period. Where an employee is not entitled to a conversion of the policy until his employment ends, this section contemplates notice will be given once the entitlement arises. *Life Ins. Co. v. Ashley*, 308 Ark. 335, 824 S.W.2d 393 (1992).

If an employee is covered by group insurance while employed, and that coverage terminates when his job terminates, nothing in this section works to extend the group coverage, but this section does provide for extension of a period in which the

employee is eligible to exercise the right of conversion from group to individual coverage. *Life Ins. Co. v. Ashley*, 308 Ark. 335, 824 S.W.2d 393 (1992).

Improper Notice.

Where the notice given prior to an employee's termination of employment did not comply with the requirements of this section, the conversion period was extended. *Life Ins. Co. v. Ashley*, 308 Ark. 335, 824 S.W.2d 393 (1992).

Necessity of Notice.

The right to convert a group policy to an

individual policy is a valuable contractual right of the discharged employee; thus to avoid the inadvertent loss of the conversion right, the insurer must give the discharged employee adequate written notice of the provision, and it must act on the insured's application for conversion in a reasonable and timely fashion. *Butler v. MFA Life Ins. Co.*, 591 F.2d 448 (8th Cir. 1979) (decision under prior law).

23-83-123. Group insurance on Arkansas residents placed in authorized insurers.

(a) All group life, annuity, and disability insurance placed by an employer on employees who are residents of this state shall be placed by the employer with an insurer authorized to transact insurance in this state.

(b) This section shall not apply to group insurance lawfully placed in an authorized insurer as a surplus line under § 23-65-101 et seq.

History. Acts 1981, No. 898, § 23; A.S.A. 1947, § 66-3523.

23-83-124. Group insurance in unauthorized insurer.

(a) Any employer in this state withholding or collecting any money from employees who are residents of this state for any group life, annuity, or disability insurance placed with an unauthorized insurer in violation of § 23-83-123 shall be deemed to be the agent of the insurer for the purpose of service of process in any action brought by any employee on the insurance contract.

(b) If the employee is unable to collect a judgment entered in an action against the unauthorized insurer, then the employer referred to in subsection (a) of this section shall be liable for the judgment.

(c) An unauthorized insurer shall be deemed to be doing business in this state for the purpose of service of process in any action.

(d) This section shall not apply to group insurance lawfully placed in an insurer as a surplus line under § 23-65-101 et seq.

History. Acts 1981, No. 898, § 24; A.S.A. 1947, § 66-3524; Acts 2001, No. 1382, § 14.

Amendments. The 2001 amendment

substituted "an insurer...§ 23-65-101 et seq." for "unauthorized insurer as a surplus line under chapter 65 of this title" in (d).

23-83-125. Assignment of rights or incidents of ownership.

Nothing in §§ 23-83-101 — 23-83-124 shall prohibit a person who is insured under any group policy from making an assignment or other-

wise disposing of all or any part of his or her rights or incidents of ownership under the policy.

History. Acts 1981, No. 898, § 25; A.S.A. 1947, § 66-3525; Acts 2001, No. 1382, § 15.

Amendments. The 2001 amendment inserted "or otherwise disposing" and "or her," and deleted "including, but not limited to, any right to surrender, cancel,

assign, pledge, or borrow against the policy, any right to designate beneficiaries thereunder, and any conversion rights upon termination of eligibility or upon termination of the policy" following "under the policy."

RESEARCH REFERENCES

Ark. L. Rev. Huff, The Irrevocable Life Insurance Trust, 38 Ark. L. Rev. 139.

23-83-126. Assignment of rights not to prejudice insurer.

Subject to the terms of the group policy relating to assignment of rights or incidents of ownership thereunder, an assignment by the insured, whether made before or after June 17, 1981, shall vest in the assignee all of such rights or incidents of ownership so assigned in accordance with any provisions of the assignment as to the effective date thereof, but the assignment shall be without prejudice to the insurer on account of any payment it may make or individual policy it may issue prior to receipt of notice of the assignment.

History. Acts 1981, No. 898, § 26; A.S.A. 1947, § 66-3526.

23-83-127. [Repealed.]

Publisher's Notes. This section, concerning right of assignment, was repealed by Acts 2001, No. 1382, § 16. The section

was derived from Acts 1981, No. 898, § 27; A.S.A. 1947, § 66-3527.

CHAPTER 84

STANDARD VALUATION LAW FOR LIFE INSURANCE AND ANNUITIES

SECTION.

- 23-84-101. Title.
- 23-84-102. Valuation of reserves by commissioner.
- 23-84-103. Minimum standard for valuation generally.
- 23-84-104. Minimum standard for valuation — Annuity and pure endowment contracts.
- 23-84-105. Minimum standard for valuation — Interest rates.
- 23-84-106. Calculation of reserves generally.

SECTION.

- 23-84-107. Calculation of reserves — Certain annuity and pure endowment contracts.
- 23-84-108. Calculation of reserves — Minimum aggregate reserves for certain life insurance policies.
- 23-84-109. Calculation of reserves — Standards of valuation.
- 23-84-110. Calculation of reserves — Certain life insurance policies and contracts.

SECTION.

23-84-111. Calculation of reserves — Future premium determinations by life insurers.

SECTION.

23-84-112. Actuarial opinion of reserves.
23-84-113. Rules and regulations.

A.C.R.C. Notes. Section 23-84-113 was added to chapter 84 by the General Assembly. (Acts 1995, No. 1272, § 19.)

Effective Dates. Acts 1961, No. 466, § 13: Mar. 16, 1961. Emergency clause provided: "It has been found, and is hereby declared, that the use of the 1958 mortality tables authorized under this act, which tables take account of the improvement in the life expectancy of the American people since the 1941 table was developed, will greatly reduce the need for deficiency reserves required under current tables and will result in keeping down the cost of life insurance; and that since use of the 1958 mortality tables has already been approved in 31 states and will probably be approved by the remaining states during their current or next legislative session, prompt enactment of this Act is desirable so that policies may be issued on a uniform basis in all such states. Therefore, an emergency is hereby declared to exist and, this Act being necessary for the preservation of the public peace, health and safety, shall take effect and be in force from and after the date of its passage and approval."

Acts 1977, No. 551, § 9: Mar. 18, 1977. Emergency clause provided: "It is hereby found and determined by the General Assembly that it is in the public interest that current money yields be recognized so as to give the benefit of these yields to policyholders of the State of Arkansas, and that this Act is necessary to accomplish these ends. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health, shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 621, § 5: Mar. 14, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws are not sufficient

to protect the Arkansas insurance buying public. It is determined that it is in the best interests of the State of Arkansas that the laws in this Act be adopted immediately so that the Arkansas Insurance Department can better regulate the insurance industry. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 624, § 5: Mar. 14, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly that the present insurance laws are not sufficient to protect the Arkansas insurance buying public. It is determined that it is in the best interests of the state of Arkansas that the laws in this act be adopted immediately so that the Arkansas Insurance Department can better regulate the insurance industry. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

23-84-101. Title.

This chapter shall be known as the "Standard Valuation Law for Life Insurance and Annuities".

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

23-84-102. Valuation of reserves by commissioner.

(a) The Insurance Commissioner shall annually value, or cause to be valued, the reserve liabilities, hereinafter called "reserves", for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state. The commissioner may certify the amount of the reserves, specifying the mortality table or tables, rate or rates of interest, and methods, which may be net level premium method or other used in the calculation of the reserves. In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(b) In lieu of the valuation of the reserves required by this section of any foreign or alien insurer, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when that valuation complies with the minimum standard provided in this section and if the official of the state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 1; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

23-84-103. Minimum standard for valuation generally.

(a) Except as otherwise provided in §§ 23-84-104 and 23-84-105, the minimum standard for the valuation of all policies and contracts issued prior to the operative date of § 23-81-213(a) shall be provided by the laws in effect immediately prior to January 1, 1960.

(b) Except as otherwise provided in §§ 23-84-104 and 23-84-105, the minimum standard for the valuation of all policies and contracts issued on or after the operative date of § 23-81-213(a) shall be the Insurance Commissioner's reserve valuation methods defined in §§ 23-84-106, 23-84-107, and 23-84-110, three and one-half percent (3.5%) interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, five and one-half percent (5.5%) interest for single premium life insurance policies and four and one-half percent

(4.5%) interest for all other policies issued on and after March 18, 1977, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies, the commissioner's 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of § 23-81-213(b) and, for policies issued on or after the operative date of § 23-81-213(d), the commissioner's 1958 Standard Ordinary Mortality Table, provided that, for any category of policies issued on female risks, all modified net premiums and present values referred to in this chapter may be calculated according to an age not more than six (6) years younger than the actual age of the insured. For such policies issued on or after the operative date of § 23-81-213(d):

(A) The commissioner's 1980 Standard Ordinary Mortality Table;

(B) At the election of the insurer, for any one (1) or more specified plans of life insurance, the commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(C) Any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the commissioner for the use in determining the minimum standard of valuation for the policies;

(2) For all industrial life insurance policies issued on the standard basis excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of § 23-81-213(c) and, for policies issued on or after the operative date, the commissioner's 1961 Standard Industrial Mortality Table, or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations promulgated by the commissioner for use in determining the minimum standard of valuation for the policies;

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the 1937 Standard Annuity Mortality Table, or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner;

(4) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the Group Annuity Mortality Table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by

regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables, or, at the option of the insurer, the Class (3) Disability Table (1926) and, for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any table, for active lives, shall be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(6) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table, or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table and, for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the commissioner.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 2; 1981, No. 535, § 1; 1961, No. 466, § 1; 1965, No. 439, § 1; A.S.A. 1947, § 66-2511.

23-84-104. Minimum standard for valuation — Annuity and pure endowment contracts.

(a) Except as provided in § 23-84-105, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section and for all annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts shall be the Insurance Commissioner's reserve valuation methods defined in §§ 23-84-106 and 23-84-107 and the following tables and interest rates:

(1) For individual single premium immediate annuity contracts excluding any disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent (7.5%) interest;

(2) For individual annuity and pure endowment contracts other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in the contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table

adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the contracts, or any modification of these tables approved by the commissioner, and five and one-half percent (5.5%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4.5%) interest for all other individual annuity and pure endowment contracts;

(3) For all annuities and pure endowments under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under the contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulations promulgated for the commissioner for use in determining the minimum standard of valuation for the annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent (7.5%) interest.

(b) After March 18, 1977, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for the insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no election, the operative date of this section for the insurer shall be January 1, 1979.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 2; 1981, No. 535, § 1; 1961, No. 466, § 1; 1965, No. 439, § 1; A.S.A. 1947, § 66-2511.

23-84-105. Minimum standard for valuation — Interest rates.

(a) **APPLICABILITY OF THIS SECTION.** The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this chapter:

(1) All life insurance policies issued in a particular calendar year, on or after the operative date of § 23-81-213(d);

(2) All individual annuity and pure endowment contracts issued in a particular calendar year on or after the operative date of § 23-81-213(e);

(3) All annuities and pure endowments purchased in a particular calendar year on or after the operative date of § 23-81-213(e), under group annuity and pure endowment contracts; and

(4) The net increase, if any, in a particular calendar year after the operative date of § 23-81-213(e), in amounts held under guaranteed interest contracts.

(b) CALENDAR YEAR STATUTORY VALUATION INTEREST RATES.

(1) The calendar year statutory valuation interest rates, I , shall be determined as follows and the results rounded to the nearer one-quarter of one percent (0.25%):

(A) For life insurance:

$$I = .03 + W (R_1 - .03) + \frac{W}{2} (R_2 - .09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$$I = .03 + W (R - .03)$$

where R_1 is the lesser of R and $.09$, R_2 is the greater of R and $.09$, R is the reference interest rate defined in subsection (d) of this section, and W is the weighting factor defined in subsection (c) of this section;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on an issue year basis, except as stated in subdivision (b)(1)(B) of this section, the formula for life insurance stated in subdivision (b)(1)(A) of this section shall apply to annuities and guaranteed interest contracts with guaranteed durations in excess of ten (10) years. The formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply to annuities and guaranteed interest contracts with guaranteed duration of ten (10) years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply; and

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision (b)(1)(B) of this section shall apply.

(2)(A) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this subdivision (b)(2)(A) differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent (0.5%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year.

(B) For purposes of applying subdivision (b)(2)(A) of this section, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 by using the reference interest rate defined for 1979 and shall be determined for each subsequent calendar year regardless of the operative date of § 23-81-213(d).

(c) WEIGHTING FACTORS.

(1) The weighting factors referred to in the formulas stated in subsection (b) of this section are given in the following tables:

(A) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision (c)(1)(B) of this section, shall be as specified in tables (i), (ii), and (iii) of this subdivision (c)(1)(C), according to the rules and definitions in tables (iv) and (v) of this subdivision (c)(1)(C):

(i) For annuities and guaranteed interest contracts valued on an issue-year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in table (i) of this subdivision (c)(1)(C) increased by:

Plan Type		
A	B	C
.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue-year basis, other than those with no cash settlement options which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis

which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in table (i) of this subdivision (c)(1)(C) or derived in table (ii) of this subdivision (c)(1)(C) increased by:

Plan Type		
A	B	C
.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guaranteed duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence;

(v) Plan type as used in the tables in this subdivision (c)(1)(C) is defined as follows:

Plan Type A: At any time, a policyholder may withdraw funds only:

(a) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

(b) Without such an adjustment but in installments over five (5) years or more;

(c) As an immediate life annuity; or

(d) No withdrawal permitted;

Plan Type B: Before expiration of the interest rate guarantee, a policyholder may withdraw funds only:

(a) With adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

(b) Without such an adjustment but in installments over five (5) years or more; or

(c) No withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such an adjustment in a single sum or installments over less than five (5) years; and

Plan Type C: A policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either:

(a) Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or

(b) Subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(2)(A)(i) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis.

(ii) Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis.

(B) As used in this chapter:

(i) "Issue-year basis of valuation" means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(ii) "Change-in-fund basis of valuation" means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) REFERENCE INTEREST RATE. The reference interest rate referred to in subsection (b) of this section shall be defined as follows:

(1) For all life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(2) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(3) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subdivision (d)(2) of this section, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subdivision (d)(2) of this section, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.;

(5) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc.; and

(6) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-

fund basis, except as stated in subdivision (d)(2) of this section, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by the Moody's Investors Service, Inc.

(e) **ALTERNATIVE METHOD FOR DETERMINING REFERENCE INTEREST RATES.** In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the Insurance Commissioner may be substituted.

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 1995, No. 624, § 1.

23-84-106. Calculation of reserves generally.

(a) Except as otherwise provided in §§ 23-84-107 and 23-84-110, reserves according to the Insurance Commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value at the date of valuation, of such future guaranteed benefits provided for by the policies, over the then-present value of any future modified net premiums therefor. The modified net premiums for any policy shall be a uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the policy, of all modified net premiums shall be equal to the sum of the then-present value of benefits provided for by the policy and the excess of subdivision (a)(1) of this section over subdivision (a)(2) of this section, as follows:

(1) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of the policy; and

(2) A net one-year-term premium for the benefits provided for in the first policy year.

(b)(1) However, for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year

exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than the excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined in this section as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium shall, except as otherwise provided in § 23-84-110, be the greater of the reserve as of the policy anniversary calculated as described in subsection (a) of this section and the reserve as of the policy anniversary calculated as described in subsection (a) of this section, but with:

(A) The value defined in subdivision (a)(1) of this section being reduced by fifteen percent (15%) of the amount of the excess first year premium;

(B) All present values of benefits and premiums being determined without reference to premiums or benefits provided by the policy after the assumed ending date; and

(C) The policy being assumed to mature on that date being considered as an endowment benefit.

(2) In making the comparison in subdivision (b)(1) of this section, the mortality and interest bases stated in §§ 23-84-104 and 23-84-105 shall be used.

(c) Reserves according to the commissioner's reserve valuation method for:

(1) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(2) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended;

(3) Disability and accidental death benefits in all policies and contracts; and

(4) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this section.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 2; 1977, No. 551, § 3; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

U.S. Code. Section 408 of the Internal Revenue Code referred to in this section is codified in 26 U.S.C. § 408.

23-84-107. Calculation of reserves — Certain annuity and pure endowment contracts.

(a) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended.

(b)(1) Reserves according to the Insurance Commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of the contract, that become payable prior to the end of the respective contract year.

(2) The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rates specified in the contracts for determining guaranteed benefits.

(3) The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 2; 1977, No. 551, § 3; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

U.S. Code. Section 408 of the Internal Revenue Code referred to in this section is codified in 26 U.S.C. § 408.

23-84-108. Calculation of reserves — Minimum aggregate reserves for certain life insurance policies.

(a) In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after June 17, 1981, be less than the aggregate reserves calculated in accordance with the methods set forth in §§ 23-84-106, 23-84-107, 23-84-110, and 23-84-111, and the mortality tables and rates of interest used in calculating nonforfeiture benefits for the policies.

(b) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by § 23-84-112.

History. Acts 1959, No. 148, § 92; A.S.A. 1947, § 66-2511; Acts 1995, No. 1977, No. 551, § 4; 1981, No. 535, § 1; 1272, § 17.

23-84-109. Calculation of reserves — Standards of valuation.

(a) Reserves for all policies and contracts issued prior to the applicable operative date of this chapter may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all the policies and contracts than the minimum reserves required by the laws in effect immediately prior to the date.

(b) Reserves for any category of policies, contracts, or benefits as established by the Insurance Commissioner which are issued on or after the applicable operative date of this chapter may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this chapter, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided therein.

(c)(1) Any insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this chapter may adopt, with the approval of the commissioner, any lower standard of valuation, but not lower than the minimum provided in this chapter.

(2) However, for the purposes of this chapter, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by § 23-84-112 shall not be deemed to be the adoption of a higher standard of valuation.

History. Acts 1959, No. 148, § 92; A.S.A. 1947, § 66-2511; Acts 1995, No. 1977, No. 551, § 5; 1981, No. 535, § 1; 1272, § 18.

23-84-110. Calculation of reserves — Certain life insurance policies and contracts.

(a) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract, or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in §§ 23-84-103 and 23-84-104.

(b)(1) However, for any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year

exceeds that of the second year and for which no comparable additional benefit is provided in the first year for the excess and which provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than the excess premium, the provisions of subsection (a) of this section shall be applied as if the method actually used in calculating the reserve for the policy was the method described in § 23-84-106, ignoring subsection (b) of that section.

(2) The minimum reserve at each policy anniversary of the policy shall be the greater of the minimum reserve calculated in accordance with § 23-84-106, including subsection (b) of that section, and the minimum reserve calculated in accordance with this section.

History. Acts 1959, No. 148, § 92; 1977, No. 551, § 6; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

23-84-111. Calculation of reserves — Future premium determinations by life insurers.

(a) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then-estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in §§ 23-84-106, 23-84-107, and 23-84-110, the reserves which are held under any such plan must be:

(1) Appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Computed by a method which is consistent with the principles of this chapter, as determined by regulations promulgated by the Insurance Commissioner.

(b) Notwithstanding any other provisions in the law of this state, any policy, contract, or certificate providing life insurance under any plan must be affirmatively approved by the commissioner before it can be marketed, issued, delivered, or used in this state.

History. Acts 1959, No. 148, § 92; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511.

23-84-112. Actuarial opinion of reserves.

(a) **GENERAL.** Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Insurance Commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. By regulation, the commissioner shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(b) ACTUARIAL ANALYSIS OF RESERVES AND ASSETS SUPPORTING SUCH RESERVES.

(1) Except as exempted by or pursuant to regulation, every life insurance company shall also annually include in the opinion required by subsection (a) of this section an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(2) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.

(c) REQUIREMENTS FOR OPINION UNDER SUBSECTION (b) OF THIS SECTION. Each opinion required by subsection (b) of this section shall be governed by the following provisions:

(1) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion;

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(d) REQUIREMENT FOR ALL OPINIONS. Every opinion shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1995;

(2) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation;

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe;

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(5) For the purposes of this section, “qualified actuary” means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in such regulations;

(6) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary’s opinion;

(7) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in regulations by the commissioner; and

(8)(A) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations promulgated under this chapter.

(B) However, the memorandum or other material may otherwise be released by the commissioner:

(i) With the written consent of the company; or

(ii) To the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(C) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

History. Acts 1995, No. 621, § 1.

23-84-113. Rules and regulations.

The Insurance Commissioner shall have the authority to promulgate reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this chapter.

History. Acts 1995, No. 1272, § 19.

CHAPTER 85

ACCIDENT AND HEALTH INSURANCE

SECTION.

- 23-85-101. Franchise plan — Definition.
- 23-85-102. Scope.
- 23-85-103. Third party ownership.
- 23-85-104. Form of policy.

SECTION.

- 23-85-105. Required provisions.
- 23-85-106. Entire contract and changes provision.
- 23-85-107. Time limit on certain defenses provision.

SECTION.

- 23-85-108. Grace period provision.
- 23-85-109. Reinstatement provision.
- 23-85-110. Notice of claim provision.
- 23-85-111. Claim forms provision.
- 23-85-112. Proofs of loss provision.
- 23-85-113. Time of payment of claims provision.
- 23-85-114. Payment of claims provision.
- 23-85-115. Physical examination and autopsy provision.
- 23-85-116. Legal actions provision.
- 23-85-117. Change of beneficiary provision.
- 23-85-118. Optional policy provisions.
- 23-85-119. Optional change of occupation provision.
- 23-85-120. Optional misstatement of age provision.
- 23-85-121. Optional other insurance in this insurer provision.
- 23-85-122. Optional relation of earnings to insurance provision.
- 23-85-123. Optional unpaid premiums provision.
- 23-85-124. Optional conformity with state statutes provision.

SECTION.

- 23-85-125. Optional illegal occupation provision.
- 23-85-126. Optional intoxicants and controlled substances provision.
- 23-85-127. Order of certain provisions.
- 23-85-128. Refusal to renew policy.
- 23-85-129. Requirements of other jurisdictions.
- 23-85-130. Conforming to statute.
- 23-85-131. Age limit — Exception.
- 23-85-132. Reduction of benefits due to other insurance contracts prohibited.
- 23-85-133. Coverage of outpatient services required — Exception — Definitions.
- 23-85-134. Refund of unearned premiums upon death of insured.
- 23-85-135. [Repealed.]
- 23-85-136. Standard claim form required.
- 23-85-137. In vitro fertilization coverage required.
- 23-85-138. [Repealed.]
- 23-85-139. Written notice for premium payments made.

Cross References. Hospital and medical service corporations, § 23-75-101 et seq.

Manner of payment of claims, § 23-63-107.

A.C.R.C. Notes. References to “this chapter” in §§ 23-85-101 — 23-85-134, 23-85-136, and 23-85-137 may not apply to § 23-85-139 which was enacted subsequently.

Preambles. Acts 1971, No. 346, contained a preamble which read: “Whereas, it is in the best interest of the public of the State of Arkansas that an individual insured under a contract of disability insurance collect all benefits for which the individual has paid a premium or premiums notwithstanding that there is in effect another contract of disability insurance providing the same or similar benefits, including services on the individual;

“Now, therefore . . .”

Effective Dates. Acts 1969, No. 263, § 8: Mar. 14, 1969. Emergency clause provided: “It is hereby found and determined by the General Assembly that there are a large number of physically handicapped

or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under mental health insurance policies and medical and hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall take effect and be enforced from and after its passage and approval.”

Acts 1971, No. 346, § 5: Mar. 22, 1971. Emergency clause provided: “It is hereby found and determined by the General Assembly that the laws of this State concerning disability insurance are totally inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for adequate protection of the public. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.”

Acts 1975, No. 404, § 8: Mar. 14, 1975.

Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 649, § 9: Mar. 28, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 729, § 9: Apr. 3, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 445, § 3: Mar. 12, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that mandating outpatient coverage for the above services will expedite the discovery and treatment of harmful conditions, alleviate overcrowding of hospitals, reduce the cost of such treatments, and that immediate passage of this Act is necessary to accomplish these desired re-

sults. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 522, § 53: Mar. 17, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 710, § 3: Mar. 23, 1983. Emergency clause provided: "It is hereby found and determined by the General Assembly that insureds who pay premiums on life insurance policies and health insurance policies should be refunded the unearned portion of such premiums upon cancellation by the insured; that such is not now provided by law, and that this Act is immediately necessary to so provide. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1985, No. 804, § 33: Apr. 3, 1985. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full force and effect from after its passage and approval."

Acts 1991, No. 920, § 6: Mar. 29, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that current regulations concerning in vitro fertilization coverage by disability insurance companies restrict the availability of this procedure to citizens of this state; that the procedure should be available to anyone seeking the service without regard to geo-

graphical location in this state; that two (2) nationally recognized organizations have established guidelines and standards for the protection of the citizens of this state; that it is in the best interests of the citizens of this state that this act become effective immediately upon its passage. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is

hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

RESEARCH REFERENCES

ALR. Health insurance: liability of insurer for damages resulting from delay in passing upon application. 18 ALR 4th 1115.

Hospital and medical expense insurers:

priority and apportionment of liability between. 25 ALR 4th 1022.

Am. Jur. 44 Am. Jur. 2d, Ins., §§ 1451-1488, 44A Am. Jur. 2d, Ins., §§ 1858, 2061.

23-85-101. Franchise plan — Definition.

(a) Accident and health insurance on a franchise plan is declared to be that form of accident and health insurance issued to:

(1) Five (5) or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency, or department thereof; or

(2) Ten (10) or more members, employees, or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two (2) years when:

(A) The association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance; and

(B) Such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by the persons under an arrangement whereby the premiums on the policies may be paid to the insurer periodically by:

(i) The employer, with or without payroll deductions;

(ii) The association for its members; or

(iii) Some designated person acting on behalf of the employer or association or union.

(b) As used in this section, the term "employees" may be deemed to include officers, managers, and employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

History. Acts 1959, No. 148, § 418; A.S.A. 1947, § 66-3633; Acts 2001, No. 909, § 2.

Amendments. The 2001 amendment substituted "Accident and health insur-

ance" for "Disability insurance" in (a); redesignated former (a)(2) as present (a)(2)(A) and (a)(2)(B); and made minor stylistic changes throughout.

23-85-102. Scope.

This chapter governs accident and health insurance policies issued to individuals and members of their families. Nothing in this section and §§ 23-85-101, 23-85-103 — 23-85-134, 23-85-136, and 23-85-137 shall apply to or affect:

(1) Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein;

(2) Any group or blanket policy;

(3) Life insurance, endowment, or annuity contracts, or contracts supplemental thereto, that contain only such provisions relating to accident and health insurance as:

(A) Provide additional benefits in case of death, dismemberment, or loss of sight by accident; or

(B) Operate to safeguard the contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; and

(4) Reinsurance.

History. Acts 1959, No. 148, § 386; A.S.A. 1947, § 66-3601; Acts 2001, No. 909, § 3.

Amendments. The 2001 amendment, in the introductory language, added "This

chapter governs...their families," and substituted "23-85-134, 23-85-136, and 23-85-137" for "23-85-131"; and substituted "accident and health" for "disability" in (3).

23-85-103. Third party ownership.

The word "insured" as used in this section and §§ 23-85-101, 23-85-102, and 23-85-104 — 23-85-131 shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

History. Acts 1959, No. 148, § 414; A.S.A. 1947, § 66-3629.

23-85-104. Form of policy.

No policy of accident and health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy shall be expressed in the policy;

(2) The time when the insurance takes effect and terminates shall be expressed in the policy;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, or any other person dependent upon the policyholder;

(4)(A) The style, arrangement, and overall appearance of the policy shall give no undue prominence to any portion of the text.

(B) In printed forms, every portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point type with a lower case unspaced alphabet length not less than one hundred twenty (120) points.

(C) The appearance of text in forms developed for electronic transmission shall comply with rules and regulations developed by the Insurance Commissioner.

(D) The text shall include all printed matter, except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in §§ 23-85-106 — 23-85-126 and 23-85-128, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions", or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risk or a short-rate table filed with the commissioner.

History. Acts 1959, No. 148, § 387; 1967, No. 418, § 1; 1969, No. 263, § 1; A.S.A. 1947, § 66-3602; Acts 2001, No. 909, § 4.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in the introductory language; substituted "in the policy" for "therein" in (1); redesignated former (4) as present (4)(A) through (4)(D); in (4)(B), substituted "In

printed forms, every" for "Every printed," "10-point type" for "ten (10) point" and "120 points" for "one hundred twenty (120) point"; added (4)(C); substituted "commissioner" for "Insurance Commissioner" in (7); and made stylistic changes throughout.

Meaning of "this code". Acts 1959, No. 148, codified as set out in the note following § 23-74-306.

23-85-105. Required provisions.

(a)(1) Except as provided in subsection (b) of this section, each accident and health policy delivered or issued for delivery to any person in this state shall contain the provisions specified in §§ 23-85-106 — 23-85-117 in the words in which the provisions appear.

(2) However, the insurer, at its option, may substitute for one (1) or more of the provisions, corresponding provisions of different wording approved by the Insurance Commissioner that are, in each instance, not less favorable in any respect to the insured or the beneficiary. Each provision shall be preceded individually by the applicable caption shown, or at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(3) For the purpose of protecting the public against misrepresentations and misleading representations regarding the benefits provided in any policy of accident and health insurance, the commissioner is directed to prescribe minimum benefit provisions that shall be included in and made a part of every policy of accident and health insurance sold or offered for sale in this state.

(b) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such manner as to make the provisions, as contained in the policy, consistent with the coverage provided by the policy.

History. Acts 1959, No. 148, § 388; A.S.A. 1947, § 66-3603; Acts 2001, No. 909, § 5.

Amendments. The 2001 amendment inserted “accident and health” in (a)(1);

substituted “insurer, at its option, may” for “insurer may, at its option” in (a)(2); and substituted “accident and health” for “disability” in (a)(3).

23-85-106. Entire contract and changes provision.

There shall be a provision as follows:

“Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.”

History. Acts 1959, No. 148, § 389; A.S.A. 1947, § 66-3604.

CASE NOTES**Substantial Compliance.**

There was no violation of this section where insurance policy which contained a

provision in substantial compliance with this section but substituted “President or Secretary of the Company” for the words

“executive officer of the insurer” used in the section and the printed policy, where the policy was signed by both the president and secretary of the company, the application was attached to the printed

policy and together they became the insurance contract, and this policy was never changed. *American Pioneer Life Ins. Co. v. Allender*, 18 Ark. App. 234, 713 S.W.2d 249 (1986).

23-85-107. Time limit on certain defenses provision.

(a) There shall be a provision as follows:

“Time Limit on Certain Defenses: (1) After three (3) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability as defined in the policy commencing after the expiration of such three-year period.

“(2) No claim for loss incurred or disability, as defined in the policy, commencing after three (3) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.”

(b) Provision number one (1) as stated in subsection (a) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three-year period, nor to limit the application of §§ 23-85-119 — 23-85-121 in the event of misstatement with respect to age or occupation or other insurance.

(c) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least fifty (50) years of age or, in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurer’s option, under the caption “Incontestable”:

“After this policy has been in force for a period of three (3) years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.”

History. Acts 1959, No. 148, § 390;
A.S.A. 1947, § 66-3605.

RESEARCH REFERENCES

UALR L.J. Adams, Misrepresentation in Procurement of Insurance: The Arkansas Law, 4 UALR L.J. 17.

23-85-108. Grace period provision.

(a) There shall be a provision as follows:

“Grace Period: A grace period of (insert a number not less than seven (7) for weekly premium policies, ten (10) for monthly premium policies and thirty-one (31) for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.”

(b) A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the provision set forth in subsection (a) of this section:

“Unless, not less than thirty (30) days prior to the premium due date, the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.”

History. Acts 1959, No. 148, § 391;
A.S.A. 1947, § 66-3606.

23-85-109. Reinstatement provision.

(a) There shall be a provision as follows:

“Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.”

(b) The last sentence of the provision set forth in subsection (a) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) Until at least fifty (50) years of age; or

(2) In the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

History. Acts 1959, No. 148, § 392;
A.S.A. 1947, § 66-3607.

23-85-110. Notice of claim provision.

(a) There shall be a provision as follows:

“Notice of Claim: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.”

(b) In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may at its option insert the following between the first and second sentences of the provision set forth in subsection (a) of this section:

“Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of the claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured’s right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.”

History. Acts 1959, No. 148, § 393;
A.S.A. 1947, § 66-3608.

23-85-111. Claim forms provision.

There shall be a provision as follows:

“Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.”

History. Acts 1959, No. 148, § 394;
A.S.A. 1947, § 66-3609.

23-85-112. Proofs of loss provision.

There shall be a provision as follows:

“Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.”

History. Acts 1959, No. 148, § 395;
A.S.A. 1947, § 66-3610.

23-85-113. Time of payment of claims provision.

There shall be a provision as follows:

“Time of Payment of Claims: Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.”

History. Acts 1959, No. 148, § 396;
A.S.A. 1947, § 66-3611.

23-85-114. Payment of claims provision.

(a) There shall be a provision as follows:

“Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured’s death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.”

(b) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

(1) “If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise

not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$..... (insert an amount which shall not exceed one thousand dollars (\$1,000)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of payment."

(2) "Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may be paid, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person."

History. Acts 1959, No. 148, § 397;
A.S.A. 1947, § 66-3612.

CASE NOTES

Assignment.

Subdivision (b)(2) provides the insurer with the option of drafting insurance policies to stipulate that payment shall be made to the provider of medical care services rather than to the insured. However, the insured can prevent the payment of benefits to the provider by so requesting, in writing, at the time of application or when submitting proof of loss. *American Medical Int'l, Inc. v. Arkansas Blue Cross*

& Blue Shield, 299 Ark. 514, 773 S.W.2d 831 (1989).

Chancellor erred in ruling that there was an irreconcilable conflict between subdivision (b)(2) of this section and § 4-58-102 causing the insurance code provisions to repeal the general law on assignments. *American Medical Int'l, Inc. v. Arkansas Blue Cross & Blue Shield*, 299 Ark. 514, 773 S.W.2d 831 (1989).

23-85-115. Physical examination and autopsy provision.

There shall be a provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

History. Acts 1959, No. 148, § 398;
A.S.A. 1947, § 66-3613.

23-85-116. Legal actions provision.

There shall be a provision as follows:

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the

expiration of three (3) years after the time written proof of loss is required to be furnished."

History. Acts 1959, No. 148, § 399;
A.S.A. 1947, § 66-3614.

23-85-117. Change of beneficiary provision.

(a) There shall be a provision as follows:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

(b) The first clause of the provision set forth in subsection (a) of this section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

History. Acts 1959, No. 148, § 400;
A.S.A. 1947, § 66-3615.

23-85-118. Optional policy provisions.

(a) Except as provided in § 23-85-105(b), no policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in this section and §§ 23-85-119 — 23-85-126, unless the provisions are in the words in which the provisions appear in the applicable section, except that the insurer may, at its option, use in lieu of the provision a corresponding provision of different wording approved by the Insurance Commissioner which is not less favorable in any respect to the insured or the beneficiary.

(b) The provision contained in the policy shall be preceded individually by the appropriate caption or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

History. Acts 1959, No. 148, § 401;
A.S.A. 1947, § 66-3616.

23-85-119. Optional change of occupation provision.

There may be a provision as follows:

"Change of Occupation: If the insured is injured or contracts sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the

insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer, prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

History. Acts 1959, No. 148, § 402;
A.S.A. 1947, § 66-3617.

23-85-120. Optional misstatement of age provision.

There may be a provision as follows:

"Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

History. Acts 1959, No. 148, § 403;
A.S.A. 1947, § 66-3618.

23-85-121. Optional other insurance in this insurer provision.

(a) There may be a provision as follows:

"Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured is in force concurrently herewith, making the aggregate indemnity for(insert type of coverage or coverages) in excess of \$...... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate."

(b) In lieu of the provision in subsection (a) of this section, there may be a provision as follows:

"Insurance effective at any one (1) time on the insured under a like policy or policies in this insurer is limited to the one (1) such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies."

History. Acts 1959, No. 148, § 404;
A.S.A. 1947, § 66-3619.

23-85-122. Optional relation of earnings to insurance provision.

(a) There may be a provision as follows:

“Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars (\$200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.”

(b)(1) The policy provision in subsection (a) of this section may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least fifty (50) years of age, or in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

(2) At its option, the insurer may include in this provision a definition of “valid loss of time coverage”, approved as to form by the Insurance Commissioner, which shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage, the inclusion of which may be approved by the commissioner or any combination of such coverages.

(3) In the absence of the definition, this term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute, including any workers’ compensation or employer’s liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

History. Acts 1959, No. 148, § 407;
A.S.A. 1947, § 66-3622.

23-85-123. Optional unpaid premiums provision.

There may be a provision as follows:

“Unpaid Premiums: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.”

History. Acts 1959, No. 148, § 408;
A.S.A. 1947, § 66-3623.

23-85-124. Optional conformity with state statutes provision.

There may be a provision as follows:

“Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state, District of Columbia, or territory in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.”

History. Acts 1959, No. 148, § 409;
A.S.A. 1947, § 66-3624.

23-85-125. Optional illegal occupation provision.

There may be a provision as follows:

“Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured’s commission of or attempt to commit a felony or to which a contributing cause was the insured’s being engaged in an illegal occupation.”

History. Acts 1959, No. 148, § 410;
A.S.A. 1947, § 66-3625.

23-85-126. Optional intoxicants and controlled substances provision.

There may be a provision as follows:

“Intoxicants and Controlled Substances: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.”

History. Acts 1959, No. 148, § 411;
1985, No. 804, § 15; A.S.A. 1947, § 66-3626.

Publisher’s Notes. Acts 1985, No. 804, § 32, provided, in part, that the act would be cumulative of prior laws, and

that no prior law or part of a law would be deemed to be in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

23-85-127. Order of certain provisions.

The provisions which are the subject of §§ 23-85-106 — 23-85-126, or any corresponding provisions which are used in lieu thereof in accordance with the sections, shall be printed in the consecutive order of the provisions in such sections. At the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided that the

resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

History. Acts 1959, No. 148, § 413;
A.S.A. 1947, § 66-3628.

23-85-128. Refusal to renew policy.

(a) Accident and health insurance policies in which the insurer reserves the right to refuse renewal on an individual basis shall provide in substance in a provision thereof, in an endorsement thereon, or rider attached thereto that, subject to the right to terminate the policy for nonpayment of premium when due, the right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on or after the next policy anniversary, or in the case of lapse and reinstatement, at the renewal date occurring on or after the next anniversary of the last reinstatement. The provision, endorsement, or rider shall also state that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force.

(b) The reference to lapse and reinstatement in subsection (a) of this section may be omitted at the insurer's option.

History. Acts 1959, No. 148, § 412;
1975, No. 729, § 6; A.S.A. 1947, § 66-3627; Acts 2001, No. 909, § 6.

Amendments. The 2001 amendment substituted "Accident and health" for "Disability" in (a).

23-85-129. Requirements of other jurisdictions.

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

(b) When issued for delivery in any other state or country, any policy of a domestic insurer may contain any provision permitted or required by the laws of the other state or country.

History. Acts 1959, No. 148, § 415;
A.S.A. 1947, § 66-3630.

23-85-130. Conforming to statute.

(a) No policy provision which is not subject to this section and §§ 23-85-101 — 23-85-129 and 23-85-131 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this section and §§ 23-85-101 — 23-85-129 and 23-85-131.

(b)(1) A policy delivered or issued for delivery to any person in this state in violation of this section and §§ 23-85-101 — 23-85-129 and

23-85-131 shall be held valid but shall be construed as provided in this section and §§ 23-85-101 — 23-85-129 and 23-85-131.

(2) When any provision in a policy subject to this section and §§ 23-85-101 — 23-85-129 and 23-85-131 is in conflict with any provision of this section and §§ 23-85-101 — 23-85-129 and 23-85-131, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this section and §§ 23-85-101 — 23-85-129 and 23-85-131.

History. Acts 1959, No. 148, § 416;
A.S.A. 1947, § 66-3631.

CASE NOTES

Cited: Robey v. Safeco Ins. Co. of Am.,
270 F. Supp. 473 (W.D. Ark. 1967).

23-85-131. Age limit — Exception.

(a) If any policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(b)(1) In any accident and health insurance contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age, and who is chiefly dependent upon the policyholder for support and maintenance shall not terminate, but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

(2) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder, except in no event shall this requirement preclude eligible dependents under this section and §§ 23-85-104, 23-86-102, and 23-86-108, regardless of age.

(3) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer.

History. Acts 1959, No. 148, § 417; 1967, No. 418, § 2; 1969, No. 263, § 2; 1975, No. 404, § 1; 1975, No. 649, §§ 1, 8; 1983, No. 522, § 47; A.S.A. 1947, §§ 66-3632, 66-3632.1; Acts 1997, No. 208, § 26; 2001, No. 909, § 7.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, codified as § 22-4-408, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code Annotated of 1987."

Publisher's Notes. Acts 1975, No. 649, § 5, as amended by Acts 1983, No. 522, § 50, provided that on March 28, 1975

any person who had previously qualified for continued coverage past age nineteen (19) years under a disability insurance policy and whose coverage thereunder had been terminated because of the failure of the insurer or corporation to request and provide an examination at the expense of the insurer to prove continuing incapacity and dependency as required by § 23-86-108 or this section, should be reinstated and included in the policy or contract coverage so long as the incapacity and dependency continued.

Acts 1983, No. 522, § 51, provided, in part, that the act would be cumulative of prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in (b)(1).

23-85-132. Reduction of benefits due to other insurance contracts prohibited.

(a) No contract of individual accident and health insurance or health coverage sold, delivered, or issued for delivery or offered for sale in this state by an insurer, hospital and medical service corporation, or health maintenance organization, directly or indirectly providing indemnity services, health care services, or cash to an individual as a result of hospitalization, medical or surgical treatment, or dental care shall contain a provision reducing the benefit that would otherwise be payable to the individual in the absence of other insurance or health coverage if the reduction of benefits is due solely to the existence of one (1) or more additional contracts providing benefits to that individual unless the reduction complies with coordination of benefit rules and regulations adopted by the Insurance Commissioner.

(b) No contract of individual accident and health insurance sold, delivered, or issued for delivery or offered for sale in this state providing disability income coverage shall contain any provision for the denial or reduction of benefits because of the existence of other insurance, except as provided in § 23-85-122 or any coverages approved by the commissioner pursuant thereto and except that the benefits may be reduced to offset disability income benefits payable under the Social Security Act.

(c) The commissioner may issue rules and regulations to implement this section, including, but not limited to, regulations as to the amount of reductions and the nature and timing of proofs of eligibility for Social Security benefits.

History. Acts 1971, No. 346, §§ 1, 2; §§ 66-3634, 66-3635; Acts 1999, No. 624, 1981, No. 809, §§ 15, 16; A.S.A. 1947, § 1; 2001, No. 909, § 8.

Amendments. The 1999 amendment rewrote (a); deleted (d); and made stylistic changes.

The 2001 amendment substituted “accident and health” for “disability” in (a) and (b).

U.S. Code. The Social Security Act, referred to in this section, is codified primarily as 42 U.S.C. § 301 et seq.

CASE NOTES

ANALYSIS

Applicability.
Medicare.

Applicability.

Former similar section applies only to individual disability insurance policies and there is no way the court can construe it to apply to automobile policies containing “no fault” coverage. *Aetna Ins. Co. v. Smith*, 263 Ark. 849, 568 S.W.2d 11 (1978) (decision under prior law).

Medicare.

Medicare is not “other insurance,” but is a statutory right and constitutes federal financial assistance; thus plaintiff’s insurance policy’s exclusionary clause prevented her from receiving benefits when her hospitalization was covered by medicare. *Vincent v. Prudential Ins. Brokerage*, 333 Ark. 414, 970 S.W.2d 215 (1998).

23-85-133. Coverage of outpatient services required — Exception — Definitions.

(a)(1) No policy or contract of accident and health insurance, including contracts issued by hospital and medical service corporations, that provides coverage for any of the following services when delivered on an inpatient basis shall be sold, delivered, or issued for delivery or offered for sale in this state unless the identical coverage for the following services is provided when delivered on an outpatient basis:

- (A) Laboratory and pathological tests;
- (B) X rays;
- (C) Chemotherapy;
- (D) Radiation treatment; and
- (E) Renal dialysis.

(2) However, the coverage required by subsection (a) of this section shall not be required when any policyholder or contract holder rejects coverage in writing.

(b) As used in this section:

(1) “Chemotherapy” means the administration, other than orally, of antineoplastic agents that are an integral part of cancer therapy;

(2) “Laboratory and pathological tests” means those services, including machine tests, ordered by the attending physician when necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of an illness or injury;

(3) “Radiation treatment” means treatment, when ordered by the attending physician, of cancer by X ray, radium, or radioisotopes;

(4) “Renal dialysis” means treatment, when ordered by the attending physician, of chronic renal disease by a process by which waste products are removed from the body by diffusion from one (1) fluid compartment

to another across a semipermeable membrane and shall include hemodialysis and peritoneal dialysis; and

(5) "X rays" means diagnostic X-ray examinations, including fluoroscopic examinations, ordered by the attending physician when such X-ray examinations are necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of an illness or injury.

History. Acts 1981, No. 445, §§ 1, 2; 1983, No. 522, § 30; A.S.A. 1947, §§ 66-3636, 66-3637; Acts 2001, No. 909, § 9.

Publisher's Notes. For cumulative effect of 1983 amendment to this section,

see Publisher's Notes to § 23-85-131.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in the introductory language of (a)(1).

23-85-134. Refund of unearned premiums upon death of insured.

(a) Upon the death of an insured, the proceeds payable to the insured or his or her estate under the policy of individual accident and health insurance, delivered or issued for delivery in this state after June 17, 1981, shall include premiums paid for accident and health insurance coverage for the insured for any period beyond the end of the policy month in which the death occurred.

(b) Unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

(c) This section shall be applicable to all individual contracts of accident and health insurance, including individual contracts issued by hospital and medical service corporations.

History. Acts 1981, No. 811, §§ 1-3; A.S.A. 1947, §§ 66-3638 — 66-3640; Acts 2001, No. 909, § 10.

Amendments. The 2001 amendment

substituted "accident and health" for "disability" in (a) and (c); and inserted "or her" in (a).

23-85-135. [Repealed.]

Publisher's Notes. This section, concerning refund of unearned premiums upon cancellation by insured, was repealed by Acts 1993, No. 901, § 42. The

section was derived from Acts 1983, No. 710, § 1.

Acts 1983, No. 710, § 1, was also codified as § 23-81-119 [repealed].

23-85-136. Standard claim form required.

(a) All accident and health insurers transacting business in this state shall use Form HCFA 1500 and Form UB-92/HCFA 1450, or the claim format required by the Health Insurance Portability and Accountability Act of 1996, as the standard claim forms until and unless the Insurance Commissioner prescribes otherwise.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, the commissioner may suspend or revoke the certificate of authority of any insurance company that refuses to use and accept the

standard claim form required by this section, or the commissioner may utilize any remedy provided in § 23-66-210.

History. Acts 1987, No. 736, § 1; 1995, No. 701, § 1; 2001, No. 909, § 11.

A.C.R.C. Notes. Acts 1987, No. 736, § 1, and Acts 1995, No. 701, § 1, are also codified as § 23-86-117.

The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148,

is codified as set out in the note following § 23-74-306.

Amendments. The 2001 amendment, in (a), substituted “All accident and health” for “As of January 1, 1996, a disability,” and inserted “or the claim...Act of 1996.”

23-85-137. In vitro fertilization coverage required.

(a) All accident and health insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, the Insurance Commissioner may suspend or revoke the certificate of authority of any insurance company failing to comply with the provisions of this section.

(c) After conducting appropriate studies and public hearings, the commissioner shall establish minimum and maximum levels of coverage to be provided by the accident and health insurance companies.

(d) Coverage required under this section shall include services performed at a medical facility, licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists’ guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

(e) Continued certification shall require that the facility is achieving a reasonable success rate with both fertilization and births.

(f) Appropriate laboratory facilities must be provided by the entity requesting certification.

History. Acts 1987, No. 779, § 1; 1991, No. 920, § 1; 2001, No. 909, § 12.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Publisher’s Notes. Acts 1987, No. 779, § 1, is also codified as § 23-86-118.

Amendments. The 2001 amendment substituted “accident and health” for “disability” in (a) and (c); and substituted “commissioner” for “Insurance Commissioner” in (c).

23-85-138. [Repealed.]

A.C.R.C. Notes. Acts 1995, No. 1272, § 20, provided: “Arkansas Code 23-85-138, as to group disability insurance policies and codified in a subchapter of the insurance laws on individual disability insurance policies after initial enactment, is hereby repealed.”

Publisher’s Notes. This section, concerning coverage for services of licensed professional counselors, was repealed by Acts 1995, No. 1272, § 20. The section was derived from Acts 1991, No. 327, § 1.

23-85-139. Written notice for premium payments made.

(a) No insurer issuing or renewing policies pursuant to this chapter or conversion policies issued pursuant to § 23-86-115 shall unilaterally change the premium payment mode for the policyholder or payor unless the insurer provides written notice of the effective date of the premium payment mode change to the policyholder or payor at least sixty (60) days prior to the change.

(b) This section shall not apply when an insurer unilaterally changes the premium payment mode solely due to a policyholder's or payor's nonpayment of premium.

History. Acts 2001, No. 1177, § 1.

A.C.R.C. Notes. References to "this chapter" in §§ 23-85-101 — 23-85-134,

23-85-136, and 23-85-137 may not apply to this section which was enacted subsequently.

CHAPTER 86**GROUP AND BLANKET ACCIDENT AND HEALTH INSURANCE****SUBCHAPTER.**

1. GENERAL PROVISIONS.
2. SMALL-EMPLOYER HEALTH INSURANCE.
3. ARKANSAS HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997.
4. FREEDOM OF CHOICE AMONG HEALTH BENEFIT PLANS ACT OF 1999.
5. SMALL EMPLOYER HEALTH INSURANCE PURCHASING GROUP ACT OF 2001.

Cross References. Hospital and medical service corporations, § 23-75-101 et seq.

Manner of payment of claims, § 23-63-107.

RESEARCH REFERENCES

ALR. Binding effect of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds. 6 ALR 4th 835.

Liability of employer to employee in connection with selection or retention of group insurer. 10 ALR 4th 1267.

Termination for employee's individual

coverage under group policy, nonpayment of premiums. 22 ALR 4th 321.

Conversion privilege of employee regarding insurance after termination of employment. 32 ALR 4th 1037.

Am. Jur. 44A Am. Jur. 2d, Ins., §§ 1841, 1856.

SUBCHAPTER 1 — GENERAL PROVISIONS**SECTION.**

- 23-86-101. Blanket accident and health insurance — Definition.
- 23-86-102. Blanket accident and health insurance — Required provisions.

SECTION.

- 23-86-103. Blanket accident and health insurance — Application and certificates not required.
- 23-86-104. Blanket accident and health

SECTION.

- insurance — Payment of benefits.
- 23-86-105. [Repealed.]
- 23-86-106. Group accident and health insurance — Definition.
- 23-86-107. Group accident and health insurance — Requires authorized insurer.
- 23-86-108. Group accident and health insurance — Required provisions.
- 23-86-109. Group accident and health insurance — Optional continuation of benefit provisions.
- 23-86-110. Group accident and health insurance — Administration of benefits.
- 23-86-111. Group accident and health insurance — Payment of benefits when other like insurance exists.
- 23-86-112. Group accident and health insurance — Direct payment

SECTION.

- of hospital or medical services.
- 23-86-113. Minimum benefits for mental illness in group accident and health policies or subscriber's contracts.
- 23-86-114. Group accident and health insurance — Continuation of coverage beyond termination of employment, change in marital status, etc.
- 23-86-115. Group accident and health insurance — Entitlement to conversion policy upon termination of group policy.
- 23-86-116. Continuation of benefits upon termination of policy.
- 23-86-117. Standard claim form required.
- 23-86-118. In vitro fertilization coverage required.
- 23-86-119. Disclosure to policyholders.
- 23-86-120. Hospice care coverage for terminally ill patients.

Effective Dates. Acts 1969, No. 263, § 8: Mar. 14, 1969. Emergency clause provided: "It is hereby found and determined by the General Assembly that there are a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical and hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is declared to exist and this Act being necessary for the preservation of the public peace, health and safety shall take effect and be enforced from and after its passage and approval."

Acts 1972 (1st Ex. Sess.), No. 49, § 4: Feb. 18, 1972. Emergency clause provided: "It is hereby found and determined by the General Assembly that the existing laws regarding the issuance of group life and disability policies in this State are not clear regarding the issuance of such policies to public employee groups; that this uncertainty should be corrected immediately in the event that the State of Arkansas or any public body should undertake to initiate a group life and/or disability

program for its employees; that this Act is designed to remove this uncertainty and to specifically authorize the issuance of such group policy in this State and should be given effect immediately. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 404, § 8: Mar. 14, 1975. Emergency clause provided: "It is hereby found and determined by the General Assembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 649, § 9: Mar. 28, 1975. Emergency clause provided: "It is hereby found and determined by the General As-

sembly that there is a large number of physically handicapped or mentally retarded dependent children in this State; that the present laws pertaining to coverage for these children under health insurance policies and medical hospital service contracts issued in this State are deficient and that there is an immediate need that this deficiency be corrected. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1975, No. 900, § 4: Apr. 7, 1975. Emergency clause provided: "It is hereby found and determined by the Seventieth General Assembly that the present laws of this State prohibit coordination of benefits under any contract of individual disability insurance issued by any insurance company or by any Hospital and Medical Service Corporation; that it is in the best interest of the citizens of this State to prohibit denial or reduction of benefits under any contract of group disability insurance including group contracts issued by Hospital and Medical Service Corporations and that this Act is designed to accomplish this. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1981, No. 810, § 2: Mar. 28, 1981. Emergency clause provided: "It is hereby found and determined by the General Assembly that the granting of authority to the Insurance Commissioner to prescribe minimum standards and benefits for Group Medicare Supplement Policies and Certificates is necessary to prevent P.L. 96-265, commonly known as the 'Baucus' amendment, from establishing federal control and responsibility for setting standards in this State when such standards are better suited to the control and review of the individual States, and that the immediate passage of this Act is necessary to prevent such federal encroachment. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1983, No. 522, § 53: Mar. 17, 1983.

Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 1985, No. 236, § 2: Aug. 1, 1985.

Acts 1985, No. 804, § 33: Apr. 3, 1985. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public. Therefore, an emergency is hereby declared to exist, and this Act being necessary for the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1987, No. 456, § 31: Mar. 30, 1987. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this act are inadequate for the protection of the public and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, and this act being necessary for the public peace, health, and safety, shall be in full force and effect from and after its passage and approval."

Acts 1991, No. 920, § 6: Mar. 29, 1991. Emergency clause provided: "It is hereby found and determined by the Seventy-Eighth General Assembly that current regulations concerning in vitro fertilization coverage by disability insurance companies restrict the availability of this procedure to citizens of this state; that the procedure should be available to anyone seeking the service without regard to geographical location in this state; that two (2) nationally recognized organizations have established guidelines and standards for the protection of the citizens of this state; that it is in the best interests of the citizens of this state that this act become effective immediately upon its passage. Therefore, an emergency is

hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1992 (1st Ex. Sess.), No. 72, § 9: Mar. 20, 1992. Emergency clause provided: "It is hereby found and determined by the General Assembly that certain provisions of the Arkansas Code concerning payment of covered services are confusing and misleading and could cause irreparable harm to citizens of Arkansas. Therefore, an emergency is hereby declared to exist and this Act being necessary for the preservation of the public peace, health and safety the provisions of this Act shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 733, § 5: Mar. 22, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly that citizens who are required to purchase conversion policies are subject to extremely high premiums, and that there

is an immediate need to provide for a reasonable level of premiums for conversion policies. Therefore, an emergency is hereby declared to exist and this act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

Acts 1995, No. 1272, § 29: Apr. 13, 1995. Emergency clause provided: "It is hereby found and determined by the General Assembly of the State of Arkansas that the present insurance laws, and motor vehicle laws on the automobile assigned risk plan, are inadequate for the protection of the public; and the immediate passage of this Insurance Omnibus Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Insurance Omnibus Act being immediately necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval."

23-86-101. Blanket accident and health insurance — Definition.

Blanket accident and health insurance is declared to be that form of accident and health insurance covering groups of persons as enumerated in one (1) of the following subdivisions:

(1) Under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on the common carrier or such means of transportation;

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees, dependents, or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents, or guests similarly defined;

(3) Under a policy or contract issued to a school or other institution of learning, camp, or sponsor thereof or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employees may be included;

(4) Under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization;

(5) Under a policy or contract issued to a sports team or sponsors thereof, which shall be deemed the policyholder, covering members, officials, and supervisors;

(6) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of the fire department or group; or

(7) Under a policy or contract issued to cover any other risk or class of risks that, in the discretion of the Insurance Commissioner, may be properly eligible for blanket accident and health insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

History. Acts 1959, No. 148, § 422; substituted “accident and health” for “disability” in the introductory paragraph and A.S.A. 1947, § 66-3704; Acts 2001, No. 1063, § 2. in (7).

Amendments. The 2001 amendment

23-86-102. Blanket accident and health insurance — Required provisions.

(a) Any insurer authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance.

(b) No blanket policy may be issued or delivered in this state unless a copy of the form shall have been filed in accordance with § 23-79-109.

(c) Every blanket policy shall contain provisions that in the opinion of the Insurance Commissioner are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties and that all statements made by the policyholder, in the absence of fraud, shall be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application;

(2)(A) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred.

(B) Failure to give notice within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(3)(A) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss.

(B) If the forms are not furnished before the expiration of fifteen (15) days after the giving of the notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(4)(A) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer

within thirty (30) days after the commencement of the period for which the insurer is liable, and the subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of loss.

(B) Failure to furnish proof within the time shall not invalidate or reduce any claim, if it shall be shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible;

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of the loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof;

(6) A provision that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished; and

(8)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age, and who is chiefly dependent upon the employee for support and maintenance shall not terminate, but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the policyholder. In no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer.

History. Acts 1959, No. 148, § 423; 1967, No. 418, § 4; 1969, No. 263, § 4; 1975, No. 404, § 3; 1975, No. 649, §§ 3, 8; 1983, No. 522, §§ 33, 48; A.S.A. 1947, § 66-3705; Acts 1997, No. 208, § 27; 2001, No. 1063, § 3.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, codified as § 22-4-408, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code Annotated of 1987."

Publisher's Notes. Acts 1975, No. 649 § 5, as amended by Acts 1983, No. 522, § 50, provided that on March 28, 1975

any person who had previously qualified for continued coverage past age nineteen (19) years under a disability insurance policy and whose coverage thereunder had been terminated because of the failure of the insurer or corporation to request and provide an examination at the expense of the insurer to prove continuing incapacity and dependency as required by § 23-86-108 or § 23-85-131, should be reinstated and included in the policy or contract coverage so long as the incapacity and dependency continued.

Acts 1983, No. 522, § 51, provided, in part, that the act would be cumulative of prior laws, and that no prior law or part of a law would be deemed in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Amendments. The 2001 amendment rewrote this section.

CASE NOTES

Physical Examination.

Dismissal, with prejudice, of an insured's suit against an insurance company to recover disability benefits was proper where the insured disobeyed a

court order to submit to a physical examination. *Fletcher v. Southern Farm Bureau Life Ins. Co.*, 757 F.2d 953 (8th Cir. 1985).

23-86-103. Blanket accident and health insurance — Application and certificates not required.

An individual application shall not be required from a person covered under a blanket accident and health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

History. Acts 1959, No. 148, § 424; A.S.A. 1947, § 66-3706; Acts 2001, No. 1063, § 4.

Amendments. The 2001 amendment substituted "accident and health" for "disability" throughout.

23-86-104. Blanket accident and health insurance — Payment of benefits.

(a)(1) All benefits under any blanket accident and health policy shall be payable to the person insured, to the designated beneficiaries, or to his or her estate.

(2) However, if the person insured is a minor or mental incompetent, the benefits may be made payable to the parent, guardian, or other person actually supporting the minor or mental incompetent. If the entire cost of the insurance has been borne by the employer, the benefits may be made payable to the employer.

(b)(1) However, the policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services, at the insurer's option, may be paid directly to the hospital or person rendering the services, but the policy may not require that the service be rendered by a particular hospital or person.

(2) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance paid.

History. Acts 1959, No. 148, § 425; A.S.A. 1947, § 66-3707; Acts 2001, No. 1063, § 5.

Amendments. The 2001 amendment substituted "accident and health" for "disability" throughout; in (a)(1), substituted "the designated" for "his designated" and

inserted "or her"; in (a)(2), substituted "the parent" for "his parent" and substituted "the minor or mental incompetent" for "him"; and substituted "services, at the insurer's option, may" for "services, may, at the insurer's option" in (b)(1).

23-86-105. [Repealed.]

Publisher's Notes. This section, concerning minimum standards for group medicare supplement policies, was repealed by Acts 1992 (1st Ex. Sess.), No. 72,

§ 6. The section was derived from Acts 1983, No. 522, § 32; A.S.A. 1947, § 66-3702.1.

For present law, see § 23-79-401 et seq.

23-86-106. Group accident and health insurance — Definition.

Group accident and health insurance is declared to be that form of accident and health insurance covering groups of persons as defined in this section, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families or one (1) or more dependents of the groups of persons, and issued upon the following basis:

(1)(A) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer.

(B) The term "employees" as used in this subdivision (1) shall be deemed to include the:

- (i) Officers, managers, and employees of the employer;
- (ii) Individual proprietor or partner, if the employer is an individual proprietor or partnership;
- (iii) Officers, managers, and employees of subsidiary or affiliated corporations; and
- (iv) Individual proprietors, partners, and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(C) The term "employees" as used in this subdivision (1):

- (i) May include retired employees; and
- (ii) Shall include members of limited liability corporations and members of limited liability partnerships.

(D) A policy issued to insure employees of a public body may provide that the term “employees” shall include elected or appointed officials.

(E) The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with the trusteeship;

(2)(A) Under a policy issued to an association, including a labor union, that shall have a constitution and bylaws and that has been organized and is maintained in good faith for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(B) The term “employees” as used in this subdivision (2) may include retired employees;

(3)(A) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one (1) or more labor unions or by one (1) or more employers and one (1) or more labor unions or by an association as defined in subdivision (2) of this section, who shall be deemed the policyholder, to insure employees of the employers or members of the unions or of the association, or employees of members of the association, for the benefit of persons other than the employers or the unions or the association.

(B) The term “employees” as used in this subdivision (3) may include:

(i) The officers, managers, and employees of the employer and the individual proprietor or partners, if the employer is an individual proprietor or partnership; and

(ii) Retired employees.

(C) The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any classes of individuals that could be insured under the group life policy; and

(5) Under a policy issued to cover any other substantially similar group that, in the discretion of the Insurance Commissioner, may be subject to the issuance of a group accident and health policy or contract.

History. Acts 1959, No. 148, § 419; 1972 (1st Ex. Sess.), No. 49, § 1; A.S.A. 1947, § 66-3701; Acts 2001, No. 1063, § 6; 2001, No. 1604, § 124[125].

Amendments. The 2001 amendment by No. 1063 substituted “accident and health” for “disability” throughout; rewrote (1)(B); redesignated the first sentence of former (2) as present (2)(A); re-

designated the second sentence of former (2) as present (2)(B) and inserted “(2)”; rewrote (3)(B) through (3)(D); and substituted “and” for “and in accord with appropriate provisions of chapter 16 of Acts 1959, No. 148 [repealed]” at the end of (4).

The 2001 amendment by No. 1604 rewrote (1)(C).

23-86-107. Group accident and health insurance — Requires authorized insurer.

(a) All group accident and health insurance placed by an employer on employees who are residents of this state shall be placed by the employer with an insurer authorized to transact insurance in this state.

(b) This section shall not apply to group insurance lawfully placed in an insurer transacting insurance as a surplus line insurer under §§ 23-65-101 et seq., 23-65-201 et seq., and 23-65-301 et seq.

History. Acts 1959, No. 148, § 426; 1985, No. 804, § 16; A.S.A. 1947, § 66-3708; Acts 2001, No. 1063, § 7.

Publisher's Notes. Acts 1985, No. 804, § 32, provided, in part, that the act would be cumulative of prior laws, and that no

prior law or part of a law would be deemed to be in conflict with the act unless failure to do so would prevent giving effect to an explicit provision of the act.

Amendments. The 2001 amendment rewrote this section.

23-86-108. Group accident and health insurance — Required provisions.

Each group accident and health insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary;

(2)(A) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits under the policy are payable.

(B) If dependents are included in the coverage, only one (1) certificate need be issued for each family unit;

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4)(A) In any contract that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of nineteen (19) years of age and who is chiefly dependent upon the employee for support and maintenance, shall not terminate, but coverage shall continue so long as the coverage of the employee or member remains in force and so long as the dependent remains in such condition.

(B) At the request and expense of the insurer, proof of the incapacity or dependency must be furnished to the insurer by the

policyholder, except in no event shall this requirement preclude eligible dependents under Acts 1975, No. 649, § 5, as amended, regardless of age.

(C) If the incapacity or dependency is thereafter removed or terminated, the policyholder shall so notify the insurer;

(5)(A) No policy or contract of group accident and health insurance, including contracts issued by hospital and medical service corporations, that provides coverage for any of the following services when delivered on an inpatient basis shall hereafter be sold, delivered, or issued for delivery or offered for sale in this state unless the identical coverage for such services is provided when delivered on an outpatient basis:

- (i) Laboratory and pathological tests;
- (ii) X rays;
- (iii) Chemotherapy;
- (iv) Radiation treatment; and
- (v) Renal dialysis.

(B) However, the coverage required by subdivision (5)(A) of this section shall not be required when any policyholder or contract holder shall reject the coverage in writing.

(C) The definition of the services referred to in this subdivision (5) shall be the same as found in § 23-85-133.

(D) All existing group contracts, including existing group contracts issued by hospital and medical service corporations, shall conform to the provisions of this subdivision (5) upon the first anniversary of the issue date, after March 12, 1981;

(6) A provision that:

(A) All benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of such loss;

(B) Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable; and

(C) Any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of due proof; and

(7)(A) Every insurer, hospital or medical service corporation, fraternal benefit society, self-funded health care plan, or health maintenance organization providing replacement coverage, with respect to group accident and health benefits within a period of sixty (60) days from the date of discontinuance of a prior plan, shall immediately cover all employees and dependents:

(i) If each employee or dependent was validly covered under the previous plan at the date of the discontinuance;

(ii) If each employee or dependent is a member of the class of individuals eligible for coverage under the succeeding carrier's plan, regardless of any of the plan's limitations or exclusions relating to "actively at work" or hospital confinement; and

(iii) Only if the group accident and health benefits were provided to a group consisting of more than fifteen (15) members.

(B) The succeeding carrier shall be entitled to deduct from its benefits any benefits payable by the previous carrier pursuant to an extension of benefits provision.

(C) No provision in a succeeding carrier's plan of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's plan shall be applied with respect to those employees and dependents validly insured under the previous carrier's policy on the date of discontinuance if benefits for the condition would have been payable under the previous carrier's plan.

(D) The provisions of this section shall apply upon the issuance of an insurance policy or health care plan:

(i) To a group whose benefits had previously been self-insured;

(ii) To a self-insurer providing coverage to a group that had been previously covered by an insurer; and

(iii) To a group that had previously been covered by an insurer.

History. Acts 1959, No. 148, § 420; 1967, No. 418, § 3; 1969, No. 263, § 3; 1975, No. 404, §§ 2, 8; 1975, No. 649, §§ 2, 8; 1981, No. 810, § 1; 1983, No. 522, §§ 31, 32; A.S.A. 1947, § 66-3702; Acts 1987, No. 456, § 17; 1987, No. 478, § 1; 1997, No. 208, § 28; 2001, No. 1063, § 8.

A.C.R.C. Notes. Acts 1997, No. 208, § 1, codified as § 22-4-408, provided: "Legislative intent and purpose. The General Assembly hereby acknowledges that many of the laws relating to individuals with disabilities are antiquated, functionally outmoded, derogatory, ambiguous or are inconsistent with more recently enacted provisions of the law. Consequently, it is the intent of the General Assembly and the purpose of this act to clarify the relevant chapters of Titles 1, 6, 9, 13, 14, 16, 17, 20, 22, 23, and 27 of the Arkansas Code Annotated of 1987."

Publisher's Notes. Acts 1975, No. 649, § 5, as amended by Acts 1983, No. 522, § 50, provided that on March 28, 1975, any person who had previously qualified for continued coverage past age nineteen (19) years under a disability insurance policy and whose coverage thereunder had been terminated because of the failure of

the insurer or corporation to request and provide an examination at the expense of the insurer to prove continuing incapacity and dependency as required by this section or § 23-85-131, should be reinstated and included in the policy or contract coverage so long as the incapacity and dependency continued.

For cumulative effect of 1983 amendment to this section, see Publisher's Notes to § 23-86-102.

Amendments. The 2001 amendment substituted "accident and health" for "disability" throughout; inserted "or her" in (1); redesignated the first sentence of former (2) as present (2)(A) and substituted "under the policy" for "thereunder"; redesignated the last sentence of former (2) as present (2)(B); redesignated the first sentence of former (4) as present (4)(A), redesignated the second sentence of former (4) as present (4)(B), and redesignated the last sentence of former (4) as present (4)(C); substituted "this subdivision (5)" for "subdivision (5) of this section" in (5)(C); substituted "this subdivision (5)" for "subdivision (5) of this section" in (5)(D); and made minor punctuation changes throughout.

23-86-109. Group accident and health insurance — Optional continuation of benefit provisions.

Any group accident and health policy that contains provisions for the payment by the insurer of benefits for expenses incurred on account of

hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of the benefit provisions, or any parts thereof, after the death of the person in the insured group.

History. Acts 1959, No. 148, § 419; A.S.A. 1947, § 66-3701; Acts 2001, No. 1063, § 9.

Amendments. The 2001 amendment substituted “accident and health” for “disability” throughout this section.

23-86-110. Group accident and health insurance — Administration of benefits.

(a)(1) All group accident and health carriers including hospital and medical service corporations shall be subject to the “primary” and “secondary” carrier rules and regulations promulgated by the Insurance Commissioner.

(2) The secondary carrier shall administer benefits on a timely basis.

(b) This section shall be applicable to all group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state, including those issued by hospital and medical service corporations, except group contracts for employees whose employer pays one hundred percent (100%) of the premiums.

History. Acts 1975, No. 900, §§ 2, 3; 1981, No. 702, § 2; A.S.A. 1947, §§ 66-3710, 66-3711; Acts 2001, No. 1063, § 10.

substituted “accident and health” for “disability” throughout; and made minor punctuation changes.

Amendments. The 2001 amendment

23-86-111. Group accident and health insurance — Payment of benefits when other like insurance exists.

(a)(1) No contract of group accident and health insurance coverage sold, delivered or issued for delivery, renewed, or offered for sale in this state by an insurer, hospital and medical service corporation, or health maintenance organization, directly or indirectly providing indemnity, services, health care services, or cash to an individual as a result of hospitalization, medical or surgical treatment, or dental care, shall contain any provision for the denial or reduction of benefits because of the existence of other like insurance except to the extent that the aggregate benefits with respect to the covered medical expenses incurred under the contract and all other like insurance with other insurers, hospital and medical service corporations, or health maintenance organizations exceed all covered medical expenses incurred.

(2) The term “other like insurance” may include group or blanket accident and health insurance or group coverage provided by health maintenance organizations, hospital and medical service corporations, government insurance plans, except Medicaid, union welfare plans, employer or employee benefit organizations, or workers’ compensation insurance or no-fault automobile coverage provided for or required by any statute.

(b)(1) No group accident and health insurance policy providing disability income coverage sold, delivered, or issued for delivery, renewed, or offered for sale in this state shall provide for reduction in the amount of the disability benefits payable to the insured to the extent of and because of the existence of other such coverage unless the policy provides a minimum amount payable, regardless of the reduction, of fifty dollars (\$50.00) per month.

(2) "Other such coverage" for which a reduction may be effected includes:

(A) Governmental programs such as Social Security, the Arkansas Public Employees' Retirement System, the state workers' compensation system, and all other government-sponsored, mandatory plans or programs that provide for disability benefit coverage;

(B) Disability or pension income coverages as established by the Insurance Commissioner through implementing rules and regulations; and

(C) Such other programs, coverages, or permissible reductions as the commissioner may establish through rules and regulations.

(3) The amount of any such reduction shall not be increased with any increase in the level of Social Security benefits payable that becomes effective after a claim commences.

(4) The commissioner may also issue rules and regulations to implement this section and § 23-86-110, including, but not limited to, the nature and timing of proofs of eligibility for Social Security benefits.

(c) This section shall be applicable to all group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state, except group contracts for employees whose employer pays one hundred percent (100%) of the premiums.

History. Acts 1975, No. 900, §§ 1, 2; 1979, No. 806, § 1; 1981, No. 702, §§ 1, 2; A.S.A. 1947, §§ 66-3709, 66-3710; Acts 1999, No. 624, § 2; 2001, No. 1063, § 11.

Amendments. The 1999 amendment rewrote (a); deleted "including those issued by hospital and medical service corporations" preceding "except group contracts" in (c); and made stylistic changes.

The 2001 amendment substituted "accident and health" for "disability" in the section heading; redesignated the first sentence of former (a) as present (a)(1)

and substituted "accident and health insurance coverage" for "disability insurance or health coverage"; redesignated the last sentence of former (a) as present (a)(2) and substituted "accident and health" for "disability"; substituted "accident and health" for "disability" in (b)(1); in (b)(2)(A), added "the Arkansas...benefit coverage" to the end and made related changes; substituted "accident and health" for disability in (c); and made minor punctuation changes in (b)(1) and (c).

CASE NOTES

ANALYSIS

Res judicata and collateral estoppel.
Social Security benefits.

Res Judicata and Collateral Estoppel.

As to applicability of doctrines of res judicata and collateral estoppel to claims,

see *Toran v. Provident Life & Accident Ins. Co.*, 297 Ark. 415, 764 S.W.2d 40 (1989).

Social Security Benefits.

Subsection (a) does not preclude an insurance company from inserting in a group disability insurance policy a clause

providing that total disability benefits under the policy would be reduced by the amount of Social Security benefits received by a disabled employee. *Milldrum v. Travelers Indem. Co.*, 285 Ark. 376, 688 S.W.2d 271 (1985).

The enumeration of various private insurance plans as constituting "other like insurance" by implication excludes from the prohibition governmental social programs such as Social Security benefits; and, therefore, the insurer may enforce a provision in its group disability insurance policy which reduces the benefits to the

insured by the amount of the Social Security payments he is entitled to receive because of his disability. *Provident Life & Accident Ins. Co. v. Toran*, 288 Ark. 63, 702 S.W.2d 10 (1986).

This section, as amended by Acts 1979, No. 806, did not prohibit an insurance company from enforcing a provision in its group disability insurance policy which reduced the benefits payable to an insured by the amount of the Social Security payments the insured received. *Garrett v. American Fid. Assurance Co.*, 305 Ark. 74, 805 S.W.2d 78 (1991).

23-86-112. Group accident and health insurance — Direct payment of hospital or medical services.

(a) On request by the group policyholder, any group accident and health policy may provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, medical, or surgical services may be paid, at the insurer's option, directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person.

(b) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance paid.

History. Acts 1959, No. 148, § 421; A.S.A. 1947, § 66-3703; Acts 2001, No. 1063, § 12.

Amendments. The 2001 amendment substituted "accident and health" for "disability" in the section heading; and, in (a), substituted "accident and health policy, on

request by the group policyholder, may" for "disability policy may, on request by the group policyholder," substituted "be paid, at the insurer's option" for "at the insurer's option, be paid," and made minor punctuation changes.

CASE NOTES

Cited: *American Medical Int'l, Inc. v. Arkansas Blue Cross & Blue Shield*, 299 Ark. 514, 773 S.W.2d 831 (1989).

23-86-113. Minimum benefits for mental illness in group accident and health policies or subscriber's contracts.

(a) Unless refused in writing, every group accident and health policy or group contract of hospital and medical service corporations issued or renewed after July 1, 1983, providing hospitalization or medical benefits to Arkansas residents for conditions arising from mental illness shall provide the following minimum benefits on and after July 1, 1983:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the

Department of Human Services, the benefits shall be as defined in subsection (b) of this section;

(2)(A) In the case of benefits provided for partial hospitalization in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services as defined in subsection (b) of this section.

(B) For the purpose of this section, "partial hospitalization" means continuous treatment for at least four (4) hours, but not more than sixteen (16) hours in any twenty-four-hour period; and

(3) In the case of outpatient benefits, the benefits shall cover services furnished by:

(A) A hospital, a psychiatric hospital, or an outpatient psychiatric center licensed by the Department of Health;

(B) A physician licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq.;

(C) A psychologist licensed under § 17-97-201 et seq.; or

(D) A community mental health center or other mental health clinic certified by the Division of Mental Health Services of the Department of Human Services to furnish mental health services as defined in subsection (b) of this section.

(b) The insurer or hospital and medical service corporation may establish a copayment requirement for mental illness benefits paid for inpatient, partial hospitalization, or outpatient care described in subsection (a) of this section, which may or may not differ from the copayment requirements for any other condition or illness, except that copayment requirements for mental illness shall not exceed a twenty percent (20%) copayment requirement.

(c)(1) For accident and health insurance sold to employers of fifty (50) or fewer employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum benefit payable, which shall not be less than seven thousand five hundred dollars (\$7,500) per calendar year.

(2) For accident and health insurance sold to employers of fifty-one (51) or more employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum of eight (8) inpatient or partial hospitalization days together with forty (40) outpatient visits.

(d) No person shall disclose mental health history, diagnosis, or treatment services information received in an initial application for coverage or subsequent claims for benefits to any person, group, organization, or governmental agency without written consent of the insured, except for purposes of:

(1) Obtaining professional review and judgments of quality and appropriateness of treatment rendered;

(2) Litigation proceedings involving the insured and when ordered by a court;

(3) Reinsurance, when required;

(4) Applying over-insurance provisions or for purposes of claiming benefits for services on behalf of the insured; or

(5) Underwriting applications for insurance coverage.

(e) Nothing in this section shall be construed to prohibit an insurer, hospital and medical service corporations, a health care plan, health maintenance organization, or other person providing accident and health insurance or medical benefits to Arkansas residents from issuing or continuing to issue an accident and health insurance benefit plan, policy, or contract that provides benefits greater than the minimum benefits required to be made available under this section or from issuing any plans, policies, or contracts that provide benefits that are generally more favorable to the insured than those required to be made available under this section.

(f) The requirements of this section with respect to a group or blanket accident and health insurance benefit plan, policy, or subscriber contract shall be satisfied, if the coverage specified is made available to the master policyholder of the plan, policy, or contract.

(g)(1)(A) Every insurer or hospital and medical service corporation that issues a group accident and health insurance policy, contract, or agreement in this state that provides for mental health coverage shall offer coverage for the payment of services rendered by licensed professional counselors.

(B) The offer shall be made either at the time of application for, or upon the first renewal of, the policy, contract, or agreement after April 1, 1995.

(C) If the offer is accepted, the amount paid for services provided by licensed professional counselors shall be subject to the same limitations as set forth in the policy for mental health coverage.

(2) Nothing in this subsection shall be deemed to expand the scope of the practice of licensed professional counselors currently licensed by the Arkansas Board of Examiners in Counseling and possessing the qualifications set forth in § 17-27-301 et seq., or other applicable laws.

History. Acts 1983, No. 326, §§ 1-5; 1985, No. 236, § 1; A.S.A. 1947, §§ 66-3716 — 66-3720; Acts 1995, No. 1272, § 21; 2001, No. 1063, § 13.

Amendments. The 2001 amendment substituted “accident and health” for “dis-

ability” throughout; substituted “provide the following minimum benefits on and after July 1, 1983” for “on and after July 1, 1983, provide the following minimum benefits” in (a); rewrote (a)(2); redesignated former (c) as present (c)(1) and substi-

tuted "For accident...employees, the" for "The"; added (c)(2); substituted "a health" for "health," in (e); in (g)(1)(B), substituted "The offer" for "Such offer" and "the pol-

icy" for "such policy"; substituted "the offer" for "such offer" in (g)(1)(C); and made minor punctuation changes.

RESEARCH REFERENCES

UALR L.J. Survey, Insurance, 12
UALR L.J. 643.

CASE NOTES

ANALYSIS

Purpose.
Right of action.

Purpose.

Only policyholders are given rights under this section, which is intended to give group policyholders additional bargaining power with insurance companies to insure that they have the option to obtain a policy with a certain level of mental

health benefits. *Sharp v. National Rural Elec. Coop. Ass'n*, 878 F. Supp. 1216 (E.D. Ark. 1994).

Right of Action.

Individual plaintiffs have no private right of action under this section, and no standing to sue the defendants for a violation of this section. *Sharp v. National Rural Elec. Coop. Ass'n*, 878 F. Supp. 1216 (E.D. Ark. 1994).

23-86-114. Group accident and health insurance — Continuation of coverage beyond termination of employment, change in marital status, etc.

(a) Every group accident and health insurance policy, contract, or certificate providing hospital, surgical, or major medical coverage, other than accident only or specified disease policies, shall contain a provision that any certificate holder, member, or spouse whose coverage under the policy would otherwise terminate due to termination of employment or membership or a change in marital status may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(b) The continued coverage need not include benefits for dental care, vision services, or prescription drug expenses.

(c)(1) Continuation of coverage shall be available only to individuals who have been insured continuously under the group policy during the three-month period prior to the termination of employment membership or change in marital status.

(2) Continuation of coverage shall not be available to an individual who is eligible for:

(A) Federal Medicare coverage; or

(B)(i) Full coverage under any other group accident and health policy or contract.

(ii) This coverage must provide benefits for all preexisting conditions to be considered full coverage.

(iii) Accordingly, under this subdivision (c)(2), an individual may continue his or her previous group coverage until all preexisting conditions are covered or would be covered under another group

policy or contract or until termination pursuant to subsection (f) of this section or pursuant to the applicable provisions of federal law.

(d) An individual who wishes to continue coverage must request continuation in writing not later than ten (10) days after the termination of employment or membership or the change in marital status.

(e) An individual who requests continuation of coverage must pay the premium required by the policyholder on a monthly basis and in advance. Payments shall be made in accordance with the group policy.

(f) Continuation of coverage shall end upon the earliest of the following dates:

(1) One hundred twenty (120) days after continuation of coverage began;

(2) The end of the period for which the individual made a timely contribution;

(3) The contribution due date following the date the individual becomes eligible for Medicare; or

(4)(A) The date on which the policy is terminated or the group withdraws from the plan.

(B) However, if the group policy is replaced, continuation shall continue under the new coverage.

(g) At the termination of the continued coverage, an individual shall be offered the conversion policy under the group policy.

(h) Individuals choosing to utilize the conversion privilege under the group policy may do so and thereby waive their right to continuation of coverage.

(i) This section shall not be applicable to health care plans in which the employer is self-insured.

History. Acts 1985, No. 814, §§ 1-10; substituted "accident and health" for "disability" throughout; inserted "(c)(2)" in §§ 66-3721 — 66-3730; Acts 1987, No. 456, § 18; 2001, No. 1063, § 14. (c)(2)(B)(iii); and added "or" to the end of (f)(3).

Amendments. The 2001 amendment

RESEARCH REFERENCES

UALR L.J. Legislative Survey, Insurance, 8 UALR L.J. 587.

23-86-115. Group accident and health insurance — Entitlement to conversion policy upon termination of group policy.

(a)(1) Every group policy, contract, or certificate of accident and health insurance delivered or issued for delivery in this state that provides hospital, surgical, or major medical coverage on an expense-incurred basis, other than coverage limited to expenses from accidents or specified diseases, shall provide that an employee, member, or covered dependent whose insurance under the group policy has been terminated for any reason, including the discontinuance of the group

policy in its entirety, shall be entitled to have issued to him or her by the insurer a policy of accident and health insurance referred to in this section as a "conversion policy".

(2) An employee, member, or dependent shall not be entitled to a conversion policy, if the termination of the group policy, contract, or certificate was a result of his or her failure to pay any required contribution or if the terminated policy is replaced by similar coverage within thirty-one (31) days.

(3) An individual wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than thirty (30) days after the termination of the group coverage.

(b)(1)(A) The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner.

(B) All conversion policies shall contain a wording in bold print that "the benefits in this policy do not necessarily equal or match those benefits provided in your previous group policy".

(2) The conversion policy shall not exclude coverage for pregnancy or other illness or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract. Moreover, the conversion policy shall include benefits for maternity coverage for any pregnancies in existence at the time of the conversion.

(c)(1) The insurer shall not be required to offer the conversion policy to any individual who is eligible for:

(A) Medicare coverage; or

(B) Full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

(2) Accordingly, under this subsection, an individual may convert to a conversion policy and remain covered by that policy until all preexisting conditions are covered or would be covered under another group policy or contract.

(d) This section shall not be applicable to self-insured plans.

(e)(1)(A) The initial premium for the conversion policy for the first twelve (12) months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered under the conversion policy and for the type and amount of insurance provided.

(B) The experience under conversion policies shall not be an acceptable basis for establishing rates for conversion policies.

(2) For purposes of subdivision (e)(1) of this section:

(A) The phrase "premium rates applicable to individually underwritten standard risks" means the premium charged to individuals who qualify for coverage without modification, determined from a rate table based on aggregate individually underwritten policy experience;

(B) "Aggregate individually underwritten policy experience" means the policy experience is drawn from a mature combination of newly selected insureds and insureds for whom selection effects no longer exist; and

(C) "Class" means any actuarially determined characteristic, except health status or individual claims experience.

(3) If an insurer experiences incurred losses that exceed earned premiums for a period of two (2) successive years on conversion policies that have been in force for at least one (1) year, the insurer may file with the commissioner amended renewal rates for the subsequent year, which will produce a loss ratio of not less than one hundred percent (100%).

(4)(A) Even though a renewal premium is established in accordance with subdivision (e)(3) of this section, a holder of the conversion policy shall not be required to pay the full renewal premium until the beginning of the policy's fourth year.

(B) The premium for the second policy year shall be the initial premium plus thirty-three and one-third percent (33 $\frac{1}{3}$ %) of the difference between the initial premium and the renewal premium in effect on the policy's first anniversary date.

(C) The premium for the third policy year shall be the initial premium plus sixty-six and two-thirds percent (66 $\frac{2}{3}$ %) of the difference between the initial premium and the renewal premium in effect on the policy's second anniversary date.

(D) The premium for the fourth year shall be one hundred percent (100%) of the renewal premium in effect on the policy's third anniversary date.

(5) This subsection shall be applicable to any conversion policy issued after March 22, 1995.

History. Acts 1985, No. 815, §§ 1-4, 6; 1985, No. 854, §§ 1-4, 6; A.S.A. 1947, §§ 66-3731 — 66-3735; Acts 1987, No. 456, §§ 19, 20; 1995, No. 733, § 1; 2001, No. 1063, § 15.

Amendments. The 2001 amendment

substituted "accident and health" for "disability" throughout; inserted "or her" in (a)(1); inserted "or her" in (a)(2); substituted "Medicare" for "medicare" in (c)(1)(A); and made minor punctuation changes.

RESEARCH REFERENCES

UALR L.J. Legislative Survey, Insurance, 8 UALR L.J. 587.

23-86-116. Continuation of benefits upon termination of policy.

(a) Every group accident and health insurance policy, contract, or certificate that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy or contract for any person insured under the policy or contract who is hospitalized on the date of termination, if the policy or contract is terminated and replaced by a group health

insurance policy or contract issued by another insurer or by a self-funded health care plan.

(b) Any payment required under this section is subject to all terms, limitations, and conditions of the policy or contract except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy or contract are exhausted, whichever is earlier.

History. Acts 1987, No. 253, § 1; 1989, No. 772, § 18; 2001, No. 1063, § 16.

substituted “accident and health” for “disability” in (a).

Amendments. The 2001 amendment

CASE NOTES

Preemption by Federal Law.

Plaintiff had no statutory cause of action for damages associated with alleged violation of this section and breach of certificate of coverage agreement by her insurer, and her cause of action sounded

in common-law contract which was preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002. *Ince v. Healthsource Ark., Inc.*, 977 F. Supp. 948 (E.D. Ark. 1997).

23-86-117. Standard claim form required.

(a) All accident and health insurers transacting business in this state shall use Form HCFA 1500 and Form UB-92/HCFA 1450 or in the claim format required by the Health Insurance Portability and Accountability Act of 1996 as the standard claim forms until and unless the Insurance Commissioner prescribes otherwise.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, the commissioner may suspend or revoke the certificate of authority of any insurance company that refuses to use and accept the standard claim form required by this section, or the commissioner may utilize any remedy provided in § 23-66-210.

History. Acts 1987, No. 736, § 1; 1995, No. 701, § 1; 2001, No. 1063, § 17.

A.C.R.C. Notes. Acts 1987, No. 736, § 1, and Acts 1995, No. 701, § 1, are also codified as § 23-85-136.

The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 2001 amendment rewrote (a).

U.S. Code. The Health Insurance Portability and Accountability Act of 1996, referred to in this section, is Act Aug. 21, 1996, P.L. 104-191, 110 Stat. 1936, codified throughout Titles 18, 26, 29, and 42 of the U.S. Code.

23-86-118. In vitro fertilization coverage required.

(a) All accident and health insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, the Insurance Commissioner may suspend or revoke the certifi-

cate of authority of any insurance company failing to comply with the provisions of this section.

(c) After conducting appropriate studies and public hearings, the commissioner shall establish minimum and maximum levels of coverage to be provided by the accident and health insurance companies.

(d) Coverage required under this section shall include services performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

History. Acts 1987, No. 779, § 1; 1991, No. 920, § 2; 2001, No. 1063, § 18.

Publisher's Notes. Acts 1987, No. 779, § 1, is also codified as § 23-85-137.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148.

Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 2001 amendment substituted "accident and health" for "disability" throughout; and made minor punctuation changes.

23-86-119. Disclosure to policyholders.

(a) Any insurer issuing or delivering group accident and health insurance policies in this state must provide to a policyholder with more than ninety-nine (99) insured employees under a comprehensive health insurance policy the following information for the most recent twelve-month period or for the entire period of coverage, whichever is shorter:

- (1) Claims incurred by month;
- (2) Premiums paid by month;
- (3) Number of insureds to include dependents by month; and
- (4) Claims exceeding ten thousand dollars (\$10,000) on any individual with diagnosis during the same period.

(b) This section does not require the insurer to disclose any information that is required by law to be confidential.

History. Acts 1999, No. 1002, § 1; 2001, No. 1063, § 19.

Amendments. The 2001 amendment inserted "accident and" in (a).

23-86-120. Hospice care coverage for terminally ill patients.

(a)(1) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other health insurance provider in the State of Arkansas shall offer to each master group contract holder, coverage for hospice facilities and hospice programs as defined under § 20-7-117.

(2)(A) The offer of these benefits shall be subject to the right of the policy or contract holder to reject the coverage.

(B) The rejection by the policy or contract holder shall be in writing.

(b) The insurance coverage required in subsection (a) of this section shall provide terminally ill patients with coverage for prognosis and treatment of at least the rates of reimbursement as are provided for hospice care under Medicare and the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as in effect January 1, 1999.

(c) This section does not apply to contracts or policies providing disability income insurance, specified disease insurance, hospital indemnity insurance, long-term care insurance, short-term limited duration insurance, accident only insurance, medicare supplement insurance, or all other supplemental insurance.

History. Acts 1999, No. 922, § 1; 2001, No. 1063, § 20.

Amendments. The 2001 amendment inserted “accident and” in (a)(1).

U.S. Code. The Health Insurance for

the Aged Act, Title XVIII of the Social Security Amendments of 1965, referred to in this section, is codified primarily as 42 U.S.C. § 1395 et seq.

SUBCHAPTER 2 — SMALL-EMPLOYER HEALTH INSURANCE

SECTION.

23-86-201. Purpose.

23-86-202. Definitions.

23-86-203. Health insurance plans subject to this subchapter.

23-86-204. Restrictions relating to premium rates.

SECTION.

23-86-205, 23-86-206. [Repealed.]

23-86-207. Maintenance of records.

23-86-208. Discretion of the commissioner.

23-86-209. Effective date.

A.C.R.C. Notes. Acts 2003, No. 470, § 1, provided: “(a) The Senate Interim Committee on Insurance and Commerce and the House Interim Committee on Insurance and Commerce shall jointly conduct a study of: (1) The feasibility and desirability of establishing a reinsurance pool or program for small employer group carriers of health insurance; and (2) The small employer health insurance rating laws under Arkansas Code §§ 23-86-201 through 23-86-209.

“(b) The committees shall complete the study and make their findings and recommendations by October 31, 2004.”

Effective Dates. Acts 1991, No. 1143, § 2: Jan. 1, 1992.

Acts 1997, No. 1000, § 30: July 2, 1997. Emergency clause provided: “It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in this

Omnibus Act are inadequate for the protection of the public. Further, the laws of this State as to Small Employer Health Insurance are not consistent with federal laws, particularly the Health Insurance Portability and Accountability Act of 1996 of the U.S. Congress; and the immediate passage of this Act is necessary in order to provide for the protection of the public. Therefore, an emergency is hereby declared to exist and this Act being immediately necessary for the preservation of the public peace, health and safety shall be in effect from and after July 2, 1997. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

23-86-201. Purpose.

The intent of this subchapter is to:

- (1) Promote the availability of health insurance coverage to small employers;
- (2) Prevent abusive rating practices; and
- (3) Improve the efficiency and fairness of the small group health insurance marketplace.

History. Acts 1991, No. 1143, § 2;
1997, No. 1000, § 18.

23-86-202. Definitions.

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individuals acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of § 23-86-204 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans;

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(3) "Carrier" means health insurance issuer, i.e., an insurance company, insurance service, or insurance organization, including a health maintenance organization that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance, but the term does not include a group health plan;

(4)(A) "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer.

(B) Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this subchapter;

(5)(A) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(B) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(i) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for the small employer carrier;

(ii) Have been acquired from another small employer carrier as a distinct grouping of plans;

(iii) Are provided through an association with membership of not less than two (2) or more small employers that has been formed for purposes other than obtaining insurance; or

(iv) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in § 23-86-204(a)(1)(A).

(C) A small employer carrier may establish no more than two (2) additional groupings under each of subdivisions (5)(B)(i), (ii), (iii), and (iv) of this section on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs.

(D) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such an action would enhance the efficiency and fairness of the small employer insurance marketplace;

(6) "Commissioner" means the Insurance Commissioner;

(7) "Department" means the State Insurance Department;

(8)(A) "Health benefit plan" or "plan" means health insurance coverage, i.e., benefits consisting of medical care, provided directly through insurance or reimbursement or otherwise, and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) "Health benefit plan" does not include:

(i) Accident-only, credit, dental, or disability income insurance;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Workers' compensation or similar insurance; or

(iv) Automobile medical-payment insurance;

(9) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(10) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(11) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

(12) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no fewer than two (2) nor more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one (1) employer; and

(13) "Small employer carrier" means health insurance issuer as defined in subdivision (3) of this section.

History. Acts 1991, No. 1143, § 2; 1997, No. 1000, § 19; 2001, No. 1063, § 21. **Amendments.** The 2001 amendment inserted "fewer than two (2) nor" in (12).

23-86-203. Health insurance plans subject to this subchapter.

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter apply to any health benefit plan that provided coverage to two (2) or more employees of a small employer.

(b) The provisions of this subchapter shall not apply to individual health insurance policies that are subject to policy form and premium rate approval as provided in §§ 23-79-109 and 23-85-101 et seq.

History. Acts 1991, No. 1143, § 2;
2001, No. 1063, § 22.

Amendments. The 2001 amendment substituted "two (2)" for "one (1)" in (a).

23-86-204. Restrictions relating to premium rates.

(a) Premium rates for health benefit plans subject to this subchapter shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). This subdivision (a)(1) shall not apply to a class of business if all of the following apply:

(A) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(B) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(C) The class of business is currently available for purchase;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A)(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period.

(ii) In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(B) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(C) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and

(4) In the case of health benefit plans issued prior to January 1, 1992, a premium rate for a rating period may exceed the ranges described in subsection (a)(1) or (2) of this section for a period of five (5) years following January 1, 1992. In such a case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A)(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period.

(ii) In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(B) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(b)(1) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates.

(2) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(c)(1) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business.

(2) A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

History. Acts 1991, No. 1143, § 2.

23-86-205, 23-86-206. [Repealed.]

Publisher's Notes. These sections, concerning provisions on renewability of coverage and disclosure of rating practices and renewability provisions, were repealed by Acts 1997, No. 1000, §§ 21, 22.

They were derived from the following sources:

- 23-86-205. Acts 1991, No. 1143, § 2.
- 23-86-206. Acts 1991, No. 1143, § 2.

23-86-207. Maintenance of records.

(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are

based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file each March 1 with the Insurance Commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification shall be retained by the carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (a) of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the State Insurance Department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

History. Acts 1991, No. 1143, § 2.

23-86-208. Discretion of the commissioner.

The Insurance Commissioner may suspend all or any part of § 23-86-204 as to the premium rates applicable to one (1) or more small employers for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

History. Acts 1991, No. 1143, § 2;
1997, No. 1000, § 22.

23-86-209. Effective date.

(a) The provisions of this subchapter shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after July 1, 1997.

(b) For purposes of this section, the date a plan is continued is the first rating period which commences after July 1, 1997.

History. Acts 1991, No. 1143, § 2; 1143, § 2, provided in part, "The provisions of this subchapter shall become effective on January 1, 1992."
1997, No. 1000, § 23.

Publisher's Notes. Acts 1991, No. 1143, § 2, provided in part, "The provisions of this subchapter shall become effective on January 1, 1992."

SUBCHAPTER 3 — ARKANSAS HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997

SECTION.	SECTION.
23-86-301. Title.	conditions exclusions.
23-86-302. Effective date — Limitation of actions — Applicability.	23-86-305. Group health plan — Application of certain rules in determination of employer size.
23-86-303. Definitions.	
23-86-304. Increased portability through limitation on preexisting	23-86-306. Prohibiting discrimination

SECTION.
against individual participants and beneficiaries based on health status.
23-86-307. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.
23-86-308. Rules of construction.
23-86-309. Special rules relating to group health plans.

SECTION.
23-86-310. Excepted benefits.
23-86-311. Guaranteed renewability of coverage for employers in the group market.
23-86-312. Guaranteed availability of coverage for employers in the group market.
23-86-313. Disclosure of information.
23-86-314. Exclusion of certain plans.

Effective Dates. Acts 1997, No. 997, § 5: Apr. 1, 1997. Emergency clause provided: “It is hereby found and determined by the General Assembly that the passage of the Health Insurance Portability and Accountability Act of 1996 by the Congress of the United States now requires amendments to existing Arkansas laws on health insurance to ensure conformity with this new Federal law. It is hereby found and determined that in this respect the present insurance laws of the State of Arkansas are not sufficient to protect the insurance buying public. It is determined that it is in the best interests of the State of Arkansas that the provisions of this Act be adopted immediately so that health

insurers, HMO’s and others shall have additional time to prepare to comply fully with the new Federal law as required no later than June 30, 1997. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health and safety shall become effective on the date of its approval by the Governor. If the bill is neither approved nor vetoed by the Governor, it shall become effective on the expiration of the period of time during which the Governor may veto the bill. If the bill is vetoed by the Governor and the veto is overridden, it shall become effective on the date the last house overrides the veto.”

23-86-301. Title.

This subchapter may be cited as the “Arkansas Health Insurance Portability and Accountability Act of 1997”.

History. Acts 1997, No. 997, § 1.

23-86-302. Effective date — Limitation of actions — Applicability.

(a) **IN GENERAL.** Except as provided in this section, this subchapter and the amendments made by this section shall apply with respect to group health plans for plan years beginning after June 30, 1997.

(b) **DETERMINATION OF CREDITABLE COVERAGE.**

(1) **PERIOD OF COVERAGE — IN GENERAL.** Subject to subdivision (b)(2)(A) of this section, no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(2) **CERTIFICATIONS.**

(A) **IN GENERAL.** Subject to subdivisions (b)(2)(B) and (C) of this section, § 23-86-304(e) shall apply to events occurring after June 30, 1996.

(B) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997. In no case is a certification required to be provided under § 23-86-304(e) before June 1, 1997.

(C) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996. In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under § 23-86-304(e) unless an individual with respect to whom the certification is otherwise required to be made requests the certification in writing.

(3) TRANSITIONAL RULE. In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996:

(A) The individual may present other credible evidence of the coverage in order to establish the period of creditable coverage; and

(B) A group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting or not crediting the coverage if the plan or issuer has sought to comply in good faith with the applicable requirements of this section.

(c) LIMITATION ON ACTIONS. No enforcement action shall be taken pursuant to this section against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by this section before January 1, 1998, or, if later, the date of issuance of regulations by the Secretary of Labor, if the plan or issuer has sought to comply in good faith with such requirements.

(d) APPLICABILITY.

(1) The provisions of this subchapter shall be applicable to all accident and health insurers, health maintenance organizations, hospital and medical service corporations, and fraternal benefit societies that are licensed and authorized by the Insurance Commissioner to transact business in the State of Arkansas.

(2) The provisions of this subchapter shall be applicable to all licensed or state-regulated multiple employer welfare arrangements, licensed or state-regulated health benefit plans, licensed or state-regulated multiple employer trusts, or other licensed or state-regulated persons providing a plan of group health insurance coverage in this state.

History. Acts 1997, No. 997, § 1; 2001, No. 1063, § 23.

substituted "accident and health" for "disability" in (d)(1).

Amendments. The 2001 amendment

23-86-303. Definitions.

As used in this subchapter:

(1) "Affiliation period" means a period that, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective;

(2) "Bona fide association" means, with respect to health insurance coverage offered in Arkansas, an association that:

(A) Has been actively in existence for at least five (5) years;

(B) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) Does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(D) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

(E) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) Meets the additional requirements that may be imposed under Arkansas law;

(3) "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA);

(4) "COBRA continuation provision" means any of the following:

(A) Part 6 of Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974, other than section 609 of the act;

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines;

(C) Title XXII of the Public Health Service Act;

(5) "Commissioner" means the Insurance Commissioner;

(6) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

(C) Part A or Part B of Title XVIII of the Social Security Act;

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(E) Chapter 55 of Title 10, United States Code;

(F) A medical care program of the Indian Health Service or of a tribal organization;

(G) A state health benefits risk pool;

(H) A health plan offered under Chapter 89 of Title 5, United States Code;

(I) A public health plan as defined in regulations;

(J) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e). The term does not include coverage consisting solely of coverage of excepted benefits as defined in § 23-86-310;

(7) "Department" means the State Insurance Department unless the context requires otherwise;

(8) "Eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in

connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined:

(A) In accordance with the terms of the plan;

(B) As provided by the issuer under rules of the issuer that are uniformly applicable in Arkansas to small employers in the small group market; and

(C) In accordance with all applicable Arkansas law governing the issuer and the market;

(9)(A) "Employee" has the meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(B) To the extent not in conflict with the Employee Retirement Income Security Act of 1974, the term "employee" also means a person who is employed by an employer for thirty (30) or more hours a week and includes an employee who is employed by a client of a professional employer organization for thirty (30) or more hours a week under a professional employer organization arrangement as governed under the Arkansas Professional Employer Organization Recognition and Licensing Act, § 23-92-401 et seq.;

(10) "Employer" has the meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two (2) or more employees;

(11) "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

(12) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of coverage of the individual in the plan or, if earlier, the first day of the waiting period for the coverage;

(13) "Federal governmental plan" means a governmental plan established or maintained for its employees by the United States Government or by any agency or instrumentality of the government;

(14) "Governmental plan" has the meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

(15) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with the plan;

(16) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care, to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

(17) "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

(18) "Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement or

otherwise and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;

(19) "Health insurance issuer" means an insurance company, insurance service, or insurance organization including a health maintenance organization as defined in this section that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance. The term does not include a group health plan;

(20) "Health maintenance organization" means:

(A) A federally qualified health maintenance organization as defined in section 1301(a) of the Public Health Service Act, 42 U.S.C. § 300e(a);

(B) An organization recognized under state law as a health maintenance organization; or

(C) A similar organization regulated under state law for solvency in the same manner and to the same extent as a health maintenance organization;

(21) "Health status-related factor" means any of the factors described in § 23-86-306(a)(1);

(22) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(23) "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one (51) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(24) "Large-group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

(25) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(A) The first period in which the individual is eligible to enroll under the plan; or

(B) A special enrollment period under § 23-86-304(f);

(26) "Medical care" means amounts paid for or services provided for:

(A) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) Amounts paid for transportation primarily for and essential to medical care referred to in subdivision (26)(A) of this section; and

(C) Amounts paid for insurance covering medical care referred to in subdivisions (26)(A) and (B) of this section;

(27) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of

medical care, including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(28) “Nonfederal governmental plan” means a governmental plan that is not a federal governmental plan;

(29) “Participant” has the meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974;

(30) “Placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child’s placement with the person terminates upon the termination of the legal obligation;

(31) “Plan sponsor” has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(32) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date;

(33) “Regulations” means rules and regulations promulgated by the Insurance Commissioner unless the context requires otherwise;

(34) “Small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(35) “Small-group market” means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a small employer;

(36) “State” means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands;

(37)(A) “State law” includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state.

(B) A law of the United States applicable only to the District of Columbia shall be treated as a state law rather than a law of the United States; and

(38) “Waiting period” means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

History. Acts 1997, No. 997, § 1; 2003, No. 1750, § 8[7].

Publisher’s Notes. Acts 2003, No. 1750, did not contain a Section 2.

Amendments. The 2003 amendment added the subdivision (9)(A) designation and inserted (9)(B).

U.S. Code. Section 3 of the Employee

Retirement Income Security Act of 1974, referred to in this section, is codified as 29 U.S.C. § 1002. Part 6 of Subtitle B of Title 1 of the Employee Retirement Security Act of 1974 is codified as 29 U.S.C. § 1161 et seq., and Section 609 is codified as 29 U.S.C. § 1169. Section 4908B of the Internal Revenue Code is codified as 26 U.S.C. § 4908B. Title XXII of the Public Health Service Act is codified as 42 U.S.C.

§ 300bb-1 et seq. Parts A and B of Title XVIII of the Social Security Act are codified as 42 U.S.C. § 1395 et seq. and 42 U.S.C. § 1395j et seq., respectively. Title XIX of the Social Security Act is codified as 42 U.S.C. § 1396 et seq., and Section 1928 is codified as 42 U.S.C. § 1396s. Chapter 55 of Title 10 is 10 U.S.C. § 1071 et seq. Chapter 89 of Title 5 is 5 U.S.C. § 8901 et seq.*

23-86-304. Increased portability through limitation on preexisting conditions exclusions.

(a) **LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD — CREDITING FOR PERIODS OF PREVIOUS COVERAGE.** Subject to subsection (d) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, as defined in subdivision (c)(1) of this section, applicable to the participant or beneficiary as of the enrollment date.

(b) **TREATMENT OF GENETIC INFORMATION.** Genetic information shall not be treated as a condition described in subdivision (a)(1) of this section in the absence of a diagnosis of the condition related to that information.

(c) **CREDITABLE COVERAGE — RULES RELATING TO CREDITING PREVIOUS COVERAGE.**

(1) **NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.**

(A) **IN GENERAL.** A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such a period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(B) **WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.** For purposes of subdivisions (c)(1)(A) and (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period as defined in § 23-86-303(1) shall not be taken into account in determining the continuous period under subdivision (c)(1)(A) of this section.

(2) METHOD OF CREDITING COVERAGE.

(A) STANDARD METHOD. Except as otherwise provided under subdivision (c)(2)(B) of this section, for purposes of applying subdivision (a)(3) of this section, a group health plan and a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) ELECTION OF ALTERNATIVE METHOD.

(i) A group health plan or a health insurance issuer offering group health insurance coverage may elect to apply subdivision (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subdivision (c)(2)(A) of this section.

(ii) The election shall be made on a uniform basis for all participants and beneficiaries.

(iii) Under the election, a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(C) PLAN NOTICE. In the case of an election with respect to a group health plan under subdivision (c)(2)(B) of this section, whether or not health insurance coverage is provided in connection with such a plan, the plan shall:

(i) Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such an election; and

(ii) Include in such statements a description of the effect of this election.

(D) ISSUER NOTICE. In the case of an election under subdivision (c)(2)(B) of this section with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(i) Shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such an election; and

(ii) Shall include in such statements a description of the effect of such an election.

(3) ESTABLISHMENT OF PERIOD. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) EXCEPTIONS.

(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS. Subject to subdivision (d)(4) of this section, a group health plan and a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(2)(A) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN. Subject to subdivision (d)(4) of this section, a group health plan and a health

insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.

(B) Subdivision (d)(2)(A) of this section shall not apply to coverage before the date of the adoption or placement for adoption.

(3) EXCLUSION NOT APPLICABLE TO PREGNANCY. A group health plan and health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) LOSS IF BREAK IN COVERAGE. Subdivisions (d)(1) and (2) of this section shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.

(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.

(A) IN GENERAL. A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subdivision (e)(1)(B) of this section:

(i) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such a provision; and

(iii)(a) At the request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision (e)(1)(A)(i) or (ii) of this section, whichever is later.

(b) The certification under subdivision (e)(1)(A)(i) of this section may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) CERTIFICATION. The certification described in subdivision (e)(1)(A) of this section is a written certification of:

(i) The period of creditable coverage of the individual under such a plan and the coverage, if any, under the COBRA continuation provision; and

(ii) The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such a plan.

(C) ISSUER COMPLIANCE. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this section if the health insurance issuer offering the coverage provides for such certification in accordance with this section.

(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS. In the case of an election described in subdivision (c)(2)(B) of this section by a group

health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (e)(1) of this section:

(A) Upon request of the plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to the requesting plan or issuer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(B) The entity may charge the requesting plan or issuer for the reasonable cost of disclosing the information.

(f) SPECIAL ENROLLMENT PERIODS.

(1) INDIVIDUALS LOSING OTHER COVERAGE. A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer if applicable required such a statement at that time and provided the employee with notice of the requirement and the consequences of such a requirement at that time;

(C) The employee's or dependent's coverage described in subdivision (f)(1)(A) of this section:

(i) Was under a COBRA continuation provision and the coverage under such a provision was exhausted; or

(ii) Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage including loss as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward the coverage were terminated; and

(D) Under the terms of the plan, the employee requests the enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subdivision (f)(1)(C)(i) of this section or termination of coverage or employer contribution described in subdivision (f)(1)(C)(ii) of this section.

(2) FOR DEPENDENT BENEFICIARIES.

(A) IN GENERAL. If:

(i) A group health plan makes coverage available with respect to a dependent of an individual;

(ii) The individual is a participant under the plan or has met any waiting period applicable to becoming a participant under the plan

and is eligible to be enrolled under the plan but for that individual's failure to enroll during a previous enrollment period; and

(iii) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, then the enrollment period described in subdivision (f)(2)(B) of this section shall be provided, during which the person, or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(B) DEPENDENT SPECIAL ENROLLMENT PERIOD. A dependent special enrollment period under subdivision (f)(2)(A) of this section shall be a period of not less than thirty (30) days and shall begin on the later of:

- (i) The date dependent coverage is made available; or
- (ii) The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subdivision (f)(2)(A)(iii) of this section.

(C) NO WAITING PERIOD. If an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

- (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
- (ii) In the case of a dependent's birth, as of the date of the birth; or
- (iii) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) USE OF AFFILIATION PERIOD BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.

(1) IN GENERAL. In the case of a group health plan that offers medical care through coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(A) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(B) The period is applied uniformly without regard to any health status-related factors; and

(C) The period does not exceed two (2) months or three (3) months in the case of a late enrollee.

(2) AFFILIATION PERIOD.

(A) AFFILIATION PERIOD. The health maintenance organization is not required to provide health care services or benefits during the period, and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) BEGINNING. The affiliation period shall begin on the enrollment date.

(C) RUNS CONCURRENTLY WITH WAITING PERIODS. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) **ALTERNATIVE METHODS.** A health maintenance organization described in subdivision (g)(1) of this section may use alternative methods from those described in subdivision (g)(1) of this section to address adverse selection as approved by the Insurance Commissioner.

History. Acts 1997, No. 997, § 1.

23-86-305. Group health plan — Application of certain rules in determination of employer size.

(a) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.** All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one (1) employer.

(b) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.** In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(c) **PREDECESSORS.** Any reference in this section to an employer shall include a reference to any predecessor of the employer.

History. Acts 1997, No. 997, § 1. Revenue Code is codified as 26 U.S.C. § 414.
U.S. Code. Section 414 of the Internal

23-86-306. Prohibiting discrimination against individual participants and beneficiaries based on health status.

(a) **INELIGIBILITY TO ENROLL.**

(1) **IN GENERAL.** Subject to subdivision (a)(2) of this section, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan may not establish rules for eligibility including continued eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (A) Health status;
- (B) Medical condition including both physical and mental illnesses;
- (C) Claims experience;
- (D) Receipt of health care;
- (E) Medical history;
- (F) Genetic information;
- (G) Evidence of insurability including conditions arising out of acts of domestic violence; or
- (H) Disability.

(2) **NO APPLICATION TO BENEFITS OR EXCLUSIONS.** To the extent consistent with § 23-86-304, subdivision (a)(1) of this section shall not be construed:

(A) To require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of such a plan or coverage; or

(B) To prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) CONSTRUCTION. For purposes of subdivision -(a)(1) of this section, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) IN PREMIUM CONTRIBUTIONS.

(1) IN GENERAL. A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require any individual as a condition of enrollment or continued enrollment under the plan to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) CONSTRUCTION. Nothing in subdivision (b)(1) of this section shall be construed to:

(A) Restrict the amount that an employer may be charged for coverage under a group health plan; or

(B) Prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing otherwise lawful premium discounts, rebates, or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

History. Acts 1997, No. 997, § 1.

23-86-307. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than:

(1) For nonpayment of contributions;

(2) For fraud or other intentional misrepresentation of material fact by the employer;

(3) For noncompliance with material plan provisions;

(4) Because the plan is ceasing to offer any coverage in a geographic area;

(5) In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this subdivision (5) uniformly without regard to the claims

experience of employers or any health status-related factor in relation to the individuals or their dependents; and

(6) For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

History. Acts 1997, No. 997, § 1.

23-86-308. Rules of construction.

Nothing in this subchapter shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such a plan or coverage.

History. Acts 1997, No. 997, § 1.

23-86-309. Special rules relating to group health plans.

(a) **GENERAL EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.** The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of the plan year, the plan has less than two (2) participants who are current employees.

(b) **EXCEPTION FOR CERTAIN BENEFITS.** The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(a).

(c) **EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.**

(1) **LIMITED, EXCEPTED BENEFITS.** The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(b) if the benefits:

(A) Are provided under a separate policy, certificate, or contract of insurance; or

(B) Are otherwise not an integral part of the plan.

(2) **NONCOORDINATED, EXCEPTED BENEFITS.** The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(c) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) **SUPPLEMENTAL EXCEPTED BENEFITS.** The requirements of this subchapter shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) **TREATMENT OF PARTNERSHIPS.**

(1) **TREATMENT AS A GROUP HEALTH PLAN.** Any plan, fund, or program which would not be, but for this subsection, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance or reimbursement or otherwise, shall be treated, subject to subdivision (d)(2) of this section, as an employee welfare benefit plan which is a group health plan.

(2) **EMPLOYER.** In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner.

(3) **PARTICIPANTS OF GROUP HEALTH PLANS.** In the case of a group health plan, the term “participant” also includes:

(A) In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(B) In connection with a group health plan maintained by a self-employed individual under which one (1) or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive a benefit under the plan or the individual’s beneficiaries may be eligible to receive any such benefit.

History. Acts 1997, No. 997, § 1.

23-86-310. Excepted benefits.

For purposes of this section, the term “excepted benefits” means benefits under one (1) or more, or any combination thereof, of the following:

(1) Benefits not subject to requirements:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers’ compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

- (2) Benefits not subject to requirements if offered separately:
 - (A) Limited scope dental or vision benefits;
 - (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
 - (C) Such other similar, limited benefits as specified in regulations;
- (3) Benefits not subject to requirements if offered as independent, noncoordinated benefits:
 - (A) Coverage only for a specified disease or illness; and
 - (B) Hospital indemnity or other fixed indemnity insurance; and
- (4) Benefits not subject to requirements if offered as separate insurance policy. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

History. Acts 1997, No. 997, § 1. section, is codified as 42 U.S.C. § 1395ss(g)(1). Chapter 55 of Title 10 is Social Security Act, referred to in this 10 U.S.C. § 1071 et seq.

23-86-311. Guaranteed renewability of coverage for employers in the group market.

(a) **IN GENERAL.** Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large-group market in connection with a group health plan, the issuer must renew or continue in force that coverage at the option of the sponsor of the plan.

(b) **GENERAL EXCEPTIONS.** A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large-group market based only on one (1) or more of the following:

(1) **NONPAYMENT OF PREMIUMS.** The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) **FRAUD.** The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) **VIOLATION OF PARTICIPATION OR CONTRIBUTION RULES.** The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules in the case of the small-group market or pursuant to applicable Arkansas law in the case of the large-group market;

(4) **TERMINATION OF COVERAGE.** The issuer is ceasing to offer coverage in such a market in accordance with subsection (c) of this section and applicable state law;

(5) **MOVEMENT OUTSIDE SERVICE AREA.** In the case of a health insurance issuer that offers health insurance coverage in the market through a

network plan, there is no longer any enrollee in connection with the plan who lives, resides, or works in the service area of the issuer, or in the area for which the issuer is authorized to do business, and, in the case of the small-group market, the issuer would deny enrollment with respect to the plan under § 23-86-312(c)(1)(A);

(6) ASSOCIATION MEMBERSHIP CEASES. In the case of health insurance coverage that is made available in the small or large-group market, as the case may be, only through one (1) or more bona fide associations, the membership of an employer in the association on the basis of which the coverage is provided ceases but only if the coverage is terminated under this subdivision (b)(6) uniformly without regard to any health status-related factor relating to any covered individual;

(7)(A) If a health insurance issuer nonrenews or discontinues group health insurance coverage under subdivision (b)(1) of this section, the health insurance issuer shall provide written notice to the individual employees insured under the group health plan so that the employees will have no fewer than fourteen (14) days to acquire alternative health coverage without loss of creditable coverage due to a break in coverage, as provided under § 23-86-304(d)(4).

(B) The Insurance Commissioner shall determine by rule or regulation the form, content, and timing of the notice under subdivision (7)(A) of this section.

(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED. In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large-group market, coverage of this type may be discontinued by the issuer in accordance with Arkansas law in such a market only if:

(A) The issuer provides notice to each plan sponsor provided coverage of this type in such a market and participants and beneficiaries covered under that coverage of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

(B) The issuer offers to each plan sponsor provided coverage of this type in such a market the option to purchase all or, in the case of the large-group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such a market; and

(C) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (c)(1)(B) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for that coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.

(A) IN GENERAL. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market, or both markets in

this state, health insurance coverage may be discontinued by the issuer only in accordance with Arkansas law and if:

(i) The issuer provides notice to the Insurance Commissioner and to each plan sponsor and participants and beneficiaries covered under the coverage of the discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of the coverage; and

(ii) All health insurance issued or delivered for issuance in this state in the market or markets is discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

(B) PROHIBITION ON MARKET REENTRY. In the case of a discontinuation under subdivision (c)(2)(A) of this section in a market, the issuer may not provide for the issuance of any health insurance coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) In the large-group market; or

(2) In the small-group market if, for coverage that is available in such a market other than only through one (1) or more bona fide associations, such a modification is consistent with Arkansas law and effective on a uniform basis among group health plans with that product.

(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS. In applying this subsection in the case of health insurance coverage that is made available by a health insurance issuer in the small-group or large-group market to employers only through one (1) or more associations, a reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such an employer.

History. Acts 1997, No. 997, § 1; 2003, No. 859, § 1.

Amendments. The 2003 amendment added (b)(7).

23-86-312. Guaranteed availability of coverage for employers in the group market.

(a) ISSUANCE OF COVERAGE IN THE SMALL GROUP MARKET — IN GENERAL. Subject to subsections (b)-(e) of this section, each health insurance issuer that offers health insurance coverage in the small-group market in Arkansas:

(1) Must accept every small employer in Arkansas that applies for that coverage; and

(2) Must accept for enrollment under the coverage every eligible individual as defined in § 23-86-303(8) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any

restriction which is inconsistent with § 23-86-306 on an eligible individual's being a participant or beneficiary.

(b) SPECIAL RULES FOR NETWORK PLANS.

(1) IN GENERAL. In the case of a health insurance issuer that offers health insurance coverage in the small-group market through a network plan, the issuer may:

(A) Limit the employers that may apply for that coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

(B) Within the service area of the plan, deny that coverage to the employers if the issuer has demonstrated, if required, to the Insurance Commissioner that:

(i) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(ii) It is applying this subsection uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) ONE-HUNDRED-EIGHTY-DAY SUSPENSION UPON DENIAL OF COVERAGE. Upon denying health insurance coverage in any service area in accordance with subdivision (b)(1)(B) of this section, an issuer may not offer coverage in the small-group market within the service area in this state for a period of one hundred eighty (180) days after the date the coverage is denied.

(c) APPLICATION OF FINANCIAL CAPACITY LIMITS.

(1) IN GENERAL. A health insurance issuer may deny health insurance coverage in the small-group market in Arkansas if the issuer has demonstrated to the commissioner that:

(A) It does not have the financial reserves necessary to underwrite additional coverage; and

(B) It is applying this subdivision (c)(1) uniformly to all employers in the small-group market in Arkansas consistent with applicable Arkansas law and without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) ONE-HUNDRED-EIGHTY-DAY SUSPENSION UPON DENIAL OF COVERAGE.

(A) Upon denying health insurance coverage in connection with group health plans in accordance with subdivision (c)(1) of this section, a health insurance issuer in Arkansas may not offer coverage in connection with group health plans in the small-group market in this state for a period of one hundred eighty (180) days after the date the coverage is denied or until the issuer has demonstrated to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(B) The commissioner may provide for the application of this subsection on a service-area-specific basis.

(d) EXCEPTION TO REQUIREMENT FOR FAILURE TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES — IN GENERAL. Subsection (a) of this

section shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small-group market, as allowed under Arkansas law.

(e) **EXCEPTION FOR COVERAGE OFFERED ONLY TO BONA FIDE ASSOCIATION MEMBERS.** Subsection (a) of this section shall not apply to health insurance coverage offered by a health insurance issuer if the coverage is made available in the small-group market only through one (1) or more bona fide associations as defined in § 23-86-303(2).

History. Acts 1997, No. 997, § 1.

23-86-313. Disclosure of information.

(a) **DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.** In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer:

(1) Shall make a reasonable disclosure to the employer as part of its solicitation and sales materials of the availability of information described in subsection (b) of this section; and

(2) Upon request of such a small employer, provide that information.

(b) **INFORMATION DESCRIBED.**

(1) **IN GENERAL.** Subject to subdivision (b)(3) of this section, with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this section is information concerning:

(A) The provisions of the coverage concerning the issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) The provisions of the coverage relating to renewability of coverage;

(C) The provisions of the coverage relating to any preexisting condition exclusion; and

(D) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) **FORM OF INFORMATION.** Information under this section shall be provided to small employers in a manner determined by the Insurance Commissioner to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) **EXCEPTION.** An issuer is not required under this section to disclose any information that is proprietary or trade secret information under applicable law.

History. Acts 1997, No. 997, § 1.

23-86-314. Exclusion of certain plans.

(a) **EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.** The requirements of § 23-86-304, limitation on preexisting conditions, § 23-86-306, prohibiting discrimination based on health status, § 23-86-311, guaranteed renewability, § 23-86-312, guaranteed availability, and § 23-86-313, disclosure of information, of this subchapter shall not apply to any group health plan and health insurance coverage offered in connection with a group health plan for any plan-year if, on the first day of the plan year, the plan has fewer than two (2) participants who are current employees.

(b) **LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.**

(1) **IN GENERAL.** The requirements of §§ 23-86-304, 23-86-306, and 23-86-311 — 23-86-313 shall apply with respect to group health plans only:

(A) Subject to subdivision (b)(2) of this section, in the case of a plan that is a nonfederal governmental plan; and

(B) With respect to health insurance coverage offered in connection with a group health plan including such a plan that is a church plan or a governmental plan.

(2) **TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.**

(A) **ELECTION TO BE EXCLUDED.** If the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of §§ 23-86-304, 23-86-306, and 23-86-311 — 23-86-313 otherwise apply makes an election under this subdivision (b)(2)(A), then the requirements of those sections insofar as they apply directly to group health plans, and not merely to group health insurance coverage, shall not apply to the governmental plans for such a period except as provided in this subsection.

(B) **PERIOD OF ELECTION.** An election under subdivision (b)(2)(A) of this section shall apply:

(i) For a single specified plan year; or

(ii) In the case of a plan provided pursuant to a collective bargaining agreement, for the term of the agreement. An election under subdivision (b)(2)(B)(i) of this section may be extended through subsequent elections under this subdivision (b)(2)(B).

(C) **NOTICE TO ENROLLEES.** Under such an election, the plan shall provide for:

(i) Notice to enrollees on an annual basis and at the time of enrollment under the plan of the fact and consequences of such an election; and

(ii) Certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with § 23-86-304(e).

(c) **EXCEPTION FOR CERTAIN BENEFITS.** The requirements of §§ 23-86-304, 23-86-306, and 23-86-311 — 23-86-313 shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(a)(1).

(d) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.

(1) LIMITED, EXCEPTED BENEFITS. The requirements of §§ 23-86-304, 23-86-306, and 23-86-311 — 23-86-313 shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(b) if the benefits:

(A) Are provided under a separate policy, certificate, or contract of insurance; or

(B) Are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS. The requirements of §§ 23-86-304, 23-86-306, and 23-86-311 — 23-86-313 shall not apply to any group health plan or group health insurance coverage offered in connection with a group health plan in relation to its provision of excepted benefits described in § 23-86-310(c) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) SUPPLEMENTAL EXCEPTED BENEFITS. The requirements of this subsection shall not apply to any group health plan or group health insurance coverage in relation to its provision of excepted benefits described in § 23-86-310(d) if the benefits are provided under a separate policy, certificate, or contract of insurance.

History. Acts 1997, No. 997, § 1.

SUBCHAPTER 4 — FREEDOM OF CHOICE AMONG HEALTH BENEFIT PLANS ACT OF 1999

SECTION.

23-86-401. Title.

23-86-402. Legislative finding.

23-86-403. Definitions.

23-86-404. Optional health benefit plans.

SECTION.

23-86-405. Effect of subchapter on pricing.

23-86-406. Effect of subchapter on coverage of specific services.

23-86-401. Title.

This subchapter may be cited as the “Freedom of Choice Among Health Benefit Plans Act of 1999”.

History. Acts 1999, No. 1469, § 1.

23-86-402. Legislative finding.

The General Assembly finds that:

(1) Citizens covered by health benefit plans should have the opportunity to obtain health care services at an affordable price;

(2) The cost of health benefit plans can vary depending upon the kind of arrangement the plan has with providers of health care services;

(3) In order to provide affordable delivery of health care services, health benefit plans which utilize contractual arrangements with providers and encourage quality services at discounted prices should be promoted; and

(4) Citizens should have the option to choose a health benefit plan that covers the services of any qualified health care provider.

History. Acts 1999, No. 1469, § 2.

23-86-403. Definitions.

As used in this subchapter:

(1) "Benefit level" means obligation of the health maintenance organization or insurance company under its health benefit plan. The benefit level is actuarially determined considering the copayments, deductibles, and dollar limits of the health benefit plan;

(2) "Covered health care services" means services rendered or products sold by a health care provider within the scope of the provider's license which are covered by a health benefit plan. The term may include hospital, medical, surgical, dental, vision, and pharmaceutical services or products;

(3) "Covered person" means any person on whose behalf a health maintenance organization is obligated to make arrangements for or pay for covered health care service;

(4) "Health benefit plan" means the agreement between an employer, association, state, county, or municipal agency and a health maintenance organization or insurance company which defines the covered services available;

(5) "Health care provider" means a hospital, an ambulatory surgery center, an outpatient psychiatric center, a home health care agency, a skilled nursing facility, or an individual licensed to render covered health care services;

(6) "Limited network plan" means a plan that arranges for or provides reimbursement for covered health care services to covered persons through a limited number of health care providers selected and employed or contracted by the health maintenance organization; and

(7) "Point-of-service plan" means a plan that provides payment of non-emergency, self-referred covered health care services obtained from providers who are not otherwise employed by nor under contract with the health maintenance organization.

History. Acts 1999, No. 1469, § 3.

23-86-404. Optional health benefit plans.

(a) A health maintenance organization may offer and issue health benefit plans that reimburse or arrange for covered health care services to covered persons through a limited network plan if:

(1) The health maintenance organization provides itself, or arranges through an insurance company, for an annual option for covered persons to choose a health benefit plan or a point-of-service plan that reimburses or arranges for the covered health care services from any health care provider qualified to render the covered health care services;

(2) The difference in the benefit level of the optional health benefit plan or point-of-service plan shall not exceed twenty-five percent (25%) of the benefit level under the limited benefit plan;

(3) The employer or other group contract holder contracting with the health maintenance organization for a health benefit plan shall provide an equal contribution per covered person regardless of which option the covered person chooses pursuant to the provisions of this subchapter; and

(4) Under the optional health benefit plan or point-of-service plan, the rate of reimbursement for health providers out of the network shall be no higher than the normal and usual and customary rate charged by those out-of-network providers on a regular basis, provided that copayment, coinsurance, and other cost-sharing features may be different for out-of-network providers and in-network providers.

(b)(1) The pricing of the optional health benefit plan or point-of-service plan must provide an expected incurred loss ratio of not less than eighty percent (80%).

(2) The Insurance Commissioner shall promulgate rules and regulations as may be necessary to implement the provisions of this subchapter and to ensure that the price of the option provided in this section bears a reasonable relationship to the costs and benefits of the limited network plan.

(c) This subchapter shall apply to any health benefit plan issued or renewed on or after January 1, 2000.

History. Acts 1999, No. 1469, § 4.

23-86-405. Effect of subchapter on pricing.

Nothing in this subchapter shall be construed to prohibit a health maintenance organization from pricing any health benefit plan according to sound actuarial principles.

History. Acts 1999, No. 1469, § 5.

23-86-406. Effect of subchapter on coverage of specific services.

Nothing in this subchapter shall be construed to require a health maintenance organization to cover any specific health care service.

History. Acts 1999, No. 1469, § 6.

**SUBCHAPTER 5 — SMALL EMPLOYER HEALTH INSURANCE PURCHASING
GROUP ACT OF 2001**

SECTION.

- 23-86-501. Title.
- 23-86-502. Definitions.
- 23-86-503. Health insurance purchasing group organization requirements.
- 23-86-504. Health insurance purchasing group health benefits coverage requirements.
- 23-86-505. Notice requirements.
- 23-86-506. Health insurance purchasing group administrative services to members.

SECTION.

- 23-86-507. Filing and form filing requirements.
- 23-86-508. Prevention of conflicts of interest.
- 23-86-509. Health insurance purchasing group operations and coordination.
- 23-86-510. Premium rates.
- 23-86-511. Regulations.
- 23-86-512. Health insurance purchasing group health carrier market.

23-86-501. Title.

This subchapter shall be known and cited as the “Small Employer Health Insurance Purchasing Group Act of 2001”.

History. Acts 2001, No. 925, § 1.

RESEARCH REFERENCES

UALR L.J. Survey of Legislation, 2001
Arkansas General Assembly, Insurance
Law, 24 UALR L.J. 577.

23-86-502. Definitions.

As used in this subchapter:

- (1) “Commissioner” means the Insurance Commissioner;
- (2) “Eligible employee” means an employee or individual who is a full-time employee of an eligible employer and is qualified to enroll in a health benefit plan offered through a health insurance purchasing group;
- (3) “Eligible employer” means an employer employing no more than one hundred (100) eligible employees;
- (4) “Employer”, “employee”, and “dependent”, unless otherwise defined in this section, shall have the meanings applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer;
- (5) “Full time” means employees working at least thirty (30) hours per week for an eligible employer;
- (6) “Health benefits plan” means a group plan, group policy, or group contract for health care services, issued or delivered by a health insurance purchasing group health carrier, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to Arkansas Constitution, Article 5, § 32, the Workers’ Compensa-

tion Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202;

(7) "Health insurer" means an insurer licensed to transact group accident and health insurance in this state;

(8) "Health maintenance organization" means a health maintenance organization as defined in § 23-76-102 that is licensed to transact business in this state as a health maintenance organization under § 23-76-107;

(9) "Health insurance purchasing group" means a health insurance purchasing group meeting the requirements of this subchapter;

(10) "Health insurance purchasing group health carrier" means a health insurer, health maintenance organization, or hospital and medical service organization;

(11) "Hospital and medical service corporation" means a hospital and medical service corporation as defined in § 23-75-101 that is licensed to transact business in this state as a hospital and medical service corporation under § 23-75-107;

(12) "Large group" means a combination of two (2) or more eligible employers belonging to a health insurance purchasing group;

(13) "Member" means an individual enrolled for health benefits coverage in a health insurance purchasing group;

(14) "Purchaser" means an eligible employer that has contracted with a health insurance purchasing group for the purchase of health benefits coverage;

(15)(A)(i) "State-mandated health benefits" means coverages for health care services or benefits required by state law or state regulations requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or the inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person.

(ii) However, for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any health care services or benefits that were mandated by Acts 1971, No. 34.

(B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115; and

(16) "Total eligible employees" means five hundred (500) or more eligible employees.

History. Acts 2001, No. 925, § 2. referred to in subdivision (15), is codified
A.C.R.C. Notes. Acts 1971, No. 34, as § 23-79-114.

23-86-503. Health insurance purchasing group organization requirements.

(a) Each health insurance purchasing group shall be a nonprofit corporation operated under the direction of a board of directors that is composed of five (5) representatives of eligible employers.

(b)(1)(A) Each health insurance purchasing group shall be composed of at least five hundred (500) eligible employees from one (1) or more eligible employers.

(B) However, a health insurance purchasing group shall have twelve (12) months from the time of formation to reach the level of five hundred (500) eligible employees.

(C) At the time of formation, the health insurance purchasing group shall have at least one hundred (100) eligible employees.

(2)(A) Upon the failure of a health insurance purchasing group to maintain the required size restrictions described in this subsection, the health insurance purchasing group shall notify the Insurance Commissioner in writing that the health insurance purchasing group does not comply with the size requirements under subdivision (b)(1) of this section.

(B) The health insurance purchasing group may then continue to operate the health benefits plan for its members but shall comply within sixty (60) calendar days with the size requirements of this section or within a time period as determined by the commissioner.

(C) Upon the failure of the health insurance purchasing group to maintain size requirements as required under this section, after sixty (60) calendar days or after the time period determined by the commissioner, the health insurance purchasing group may then be terminated following notice and hearing before the commissioner.

(c)(1)(A) Subject to the provisions of this subchapter, a health insurance purchasing group shall permit any eligible employer that meets the membership requirements of the health insurance purchasing group to contract with the health insurance purchasing group for the purchase of a health benefits plan for its eligible employees and dependents of those eligible employees.

(B) The health insurance purchasing group may not vary conditions of eligibility, including premium rates and membership fees, for any employer meeting the membership requirements of the health insurance purchasing group, nor may it vary conditions of eligibility for any employee to qualify for a health insurance purchasing group health benefits plan offered to the eligible employer by the group health insurance purchasing group.

(2)(A) A contract shall provide that the purchaser agrees not to obtain or sponsor a health benefits plan on behalf of any eligible employees and their dependents other than through the health insurance purchasing group.

(B) Subdivision (c)(2)(A) of this section shall not be construed to apply to an eligible individual who resides in an area for which no

coverage is offered by a health insurance purchasing group health carrier.

(3)(A)(i) Under rules established to carry out this subchapter with respect to an eligible employer that has a purchaser contract with a health insurance purchasing group, individuals who are eligible employees of an eligible employer may enroll for a health benefits plan offered by a health insurance purchasing group health carrier.

(ii) This may include coverage for dependents of the enrolling employees if this coverage is offered.

(B) The employees may enroll for health benefits provided through their employer's contract with a health insurance purchasing group.

(4) A health insurance purchasing group shall not deny enrollment as a member to an individual who is an eligible employee or dependent of an employee qualified to be enrolled based on health status-related factors except as may be permitted by law.

(5) In the case of members enrolled in a health benefits plan offered by a health insurance purchasing group health carrier, the health insurance purchasing group shall provide for an annual open enrollment period of thirty (30) calendar days during which the members may change the coverage option in which the members are enrolled.

(6)(A) Nothing in this subsection shall preclude a health insurance purchasing group from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subdivision (c)(5) of this section.

(B) The rules shall be applied consistently to all purchasers and members within the health insurance purchasing group and shall not be based in any manner on health status-related factors and shall not conflict with sections of this subchapter.

(d)(1) Each health insurance purchasing group shall annually file with the commissioner a description of its:

(A) Plan of operation, including each of the products it intends to sell;

(B) Marketing methods and materials; and

(C) Membership and disclosure requirements or other information as required by the commissioner through rules and regulations.

(2) The plan of operation filed with the commissioner by the health insurance purchasing group pursuant to this subsection shall be deemed approved sixty (60) calendar days after the date of filing unless additional time is requested by the commissioner to review the plan.

(e) Each health insurance purchasing group shall be considered a large group for purposes of application of the Arkansas Insurance Code to the activities and health benefit plans of the health insurance purchasing group unless stated otherwise in this subchapter.

(f) No purchaser, health insurance purchasing group, health maintenance organization, or health insurer providing coverage to a health insurance purchasing group shall be subject to any provisions in § 26-57-601 et seq. for insurance premiums collected for health benefit plans of health insurance purchasing groups.

History. Acts 2001, No. 925, § 3; 2003, No. 1358, § 1.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-74-306.

Amendments. The 2003 amendment deleted (c)(2) and redesignated the remaining subdivisions accordingly; and added (f).

23-86-504. Health insurance purchasing group health benefits coverage requirements.

(a) In conjunction with a health insurance purchasing group health carrier, each health insurance purchasing group shall make available a health benefits plan in the manner described in this section to all eligible employers and eligible employees at rates, including employer's and employees' share, on a policy-specific or product-specific basis that may vary only as permitted under law.

(b) Subject to subsection (c) of this section, a health insurance purchasing group shall not offer a health benefits plan that unfairly discriminates against eligible employees.

(c) Nothing in this subchapter shall be construed as requiring a health insurance purchasing group health carrier to provide coverage outside the service area of the insurer or organization.

(d) Each health insurance purchasing group shall provide a health benefits plan only through contracts with health insurance purchasing group health carriers and shall not assume insurance risk with respect to the coverage.

(e) Except as provided in this subchapter, the health insurance purchasing group may provide a health benefits plan in whole or in part, not subject to state-mandated health benefits, except those required in the Arkansas Health Insurance Portability and Accountability Act of 1997, § 23-86-301 et seq.

(f) The health insurance purchasing group shall offer at least two (2) types of plans including one (1) plan providing a choice of deductibles with state-mandated health benefits.

(g) The health insurance purchasing group may also offer a health benefits plan not subject to state-mandated health benefits that does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific health illness, injury, or condition of the insured, for the provisions as may be determined by rules and regulations of the Insurance Commissioner.

(h)(1) Every health benefits plan offered through a health insurance purchasing group shall:

(A) Be underwritten by a health insurance purchasing group health carrier that:

(i) Is licensed or otherwise regulated under state law;

(ii) Meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct; and

(iii) Offers the coverage under a contract with the health insurance purchasing group;

(B) Be approved or otherwise permitted to be offered under law;

(C) Provide full portability of creditable coverage for individuals who remain members of the same health insurance purchasing group, notwithstanding that they change the eligible employer through which they are members; and

(D) Comply with the provisions of the Arkansas Insurance Code in their sales and solicitation of insurance, including, but not limited to, the Trade Practices Act, § 23-66-201 et seq., and the requirements of §§ 23-64-201 and 23-64-102(1) that all insurance must be sold by an agent licensed by the State Insurance Department.

(2)(A) Any agent referenced in subdivision (h)(1)(D) of this section shall be required to obtain at least two (2) hours of continuing education on a health insurance purchasing group or the plans the health insurance purchasing group sponsors each year, or both.

(B) The requirement in subdivision (h)(2)(A) of this section shall be considered as part of the continuing education requirements provided in § 23-64-301 and shall not preempt or conflict with the provision.

(i) A health insurance purchasing group shall be exempt from the requirements of § 23-86-201 et seq.

(j) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group health carrier from offering a health benefits plan through a health insurance purchasing group by establishing premium discounts for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the health insurance purchasing group and comply with all other provisions of this subchapter and do not discriminate among similarly situated members.

History. Acts 2001, No. 925, § 4; 2003, No. 1358, § 2.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

Amendments. The 2003 amendment substituted “may provide a health benefits plan” for “may develop or offer a health benefits plan for its members” in (e); and deleted “to its members” following “plans” in (f).

23-86-505. Notice requirements.

In each sale of a health benefits plan to a proposed eligible employer through a health insurance purchasing group in which the health insurance purchasing group offers an option to an eligible employer to obtain a health benefits plan that, either in whole or in part, does not provide state-mandated health benefits or does not contain standard provisions as may be determined by rules and regulations of the Insurance Commissioner, the health insurance purchasing group, after the employer has selected its health benefit plan, shall provide to each eligible employee of the employer a written notice, in a form and

manner as prescribed by rule or regulation promulgated by the commissioner, that one (1) or more mandated benefits are not included in the health benefit plan.

History. Acts 2001, No. 925, § 5; 2003, No. 1358, § 3.

Amendments. The 2003 amendment rewrote this section.

23-86-506. Health insurance purchasing group administrative services to members.

(a)(1) Each health insurance purchasing group may provide administrative services for its members.

(2) The services may include, but are not limited to, accounting, billing, enrollment information, and employee coverage status reports.

(b) The health insurance purchasing group may delegate or contract its billing and other administrative duties to a third-party administrator as defined under § 23-92-201 in compliance with the Arkansas Insurance Code.

(c) Nothing in this section shall be construed as preventing a health insurance purchasing group from serving as an administrative service organization to any entity.

(d)(1) Each health insurance purchasing group shall collect and disseminate or arrange for the collection and dissemination of consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the health insurance purchasing group to its members.

(2) The information shall be defined by the health insurance purchasing group and shall be in a manner appropriate to the type of coverage offered.

(3) To the extent practicable, the information shall include information on provider performance, locations, and hours of operation of providers, outcomes, and similar matters.

(4) Nothing in this section shall be construed as preventing the dissemination of the information or other information by the health insurance purchasing group or by the health care insurer, health maintenance organization, or organization through electronic or other means.

(e) The contract between a health insurance purchasing group and a health insurance purchasing group health carrier shall provide that the health insurance purchasing group may collect premiums on behalf of the issuer for coverage, less a predetermined administrative charge negotiated by the health insurance purchasing group and the issuer.

History. Acts 2001, No. 925, § 6.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-74-306.

23-86-507. Filing and form filing requirements.

Each health insurance purchasing group shall file forms as may be described by rules and regulations of the Insurance Commissioner.

History. Acts 2001, No. 925, § 7.

23-86-508. Prevention of conflicts of interest.

(a) A member of a board of directors of a health insurance purchasing group shall not serve as an employee or paid consultant to the health insurance purchasing group but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

(b) An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a health insurance purchasing group or as an employee of the health insurance purchasing group, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the health insurance purchasing group receives contributions, grants, or other funds not connected with a contract for coverage through the health insurance purchasing group.

(c)(1) An individual who is serving on a board of directors of a health insurance purchasing group as a representative described in subsection (b) of this section shall not be employed by or affiliated with a health insurance purchasing group health carrier.

(2) For purposes of subdivision (c)(1) of this section, the term "affiliated" does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance purchasing group health carrier.

History. Acts 2001, No. 925, § 8.

23-86-509. Health insurance purchasing group operations and coordination.

(a) Nothing in this subchapter shall be construed as preventing one (1) or more health insurance purchasing groups serving different areas, whether or not contiguous, from providing for some or all of the following through a single administrative organization or otherwise:

(1) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different health insurance purchasing groups; or

(2) Providing for crediting of deductibles and other cost-sharing for individuals who are provided a health benefits plan through the health insurance purchasing group or affiliated health insurance purchasing group after:

(A) A change of eligible employers through which the coverage is provided; or

(B) A change in place of employment to an area not served by the previous health insurance purchasing group.

(b) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group from providing for adjustments in amounts distributed among the health insurance purchasing group health carrier offering a health benefits plan through the health insurance purchasing group, based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

(c) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group from establishing minimum participation and contribution rules for eligible employers that apply to become purchasers in the health insurance purchasing group, so long as the rules are applied uniformly for all health insurance purchasing group health carriers.

History. Acts 2001, No. 925, § 9.

23-86-510. Premium rates.

(a) The health insurance purchasing group may determine what rating characteristics it will allow in the health benefit plan, including, but not limited to, age, sex, industry, geography, or health.

(b) If health is used as a rating characteristic, then the rates for the size groups two (2) through twenty-five (25) will be subject to the small group rating law as required in § 23-86-201 et seq. but may be considered separate from any small groups sold outside the health insurance purchasing group.

History. Acts 2001, No. 925, § 10.

23-86-511. Regulations.

The Insurance Commissioner may promulgate regulations necessary to implement the provisions of this subchapter.

History. Acts 2001, No. 925, § 11.

23-86-512. Health insurance purchasing group health carrier market.

No health insurance purchasing group health carrier shall be required to offer health insurance purchasing group health benefits plans or health benefits plans not subject to state-mandated health benefits to nonhealth insurance purchasing group organizations, associations, or employer groups, including, but not limited to, the small employer health insurance group marketplace in this state.

History. Acts 2001, No. 925, § 12.

CHAPTER 87

MODEL ACT FOR THE REGULATION OF CREDIT LIFE
INSURANCE AND CREDIT DISABILITY INSURANCE

SECTION.

- 23-87-101. Title.
- 23-87-102. Purpose.
- 23-87-103. Definitions.
- 23-87-104. Scope.
- 23-87-105. Construction.
- 23-87-106. Penalties.
- 23-87-107. Policy forms.
- 23-87-108. Amount.
- 23-87-109. Term.
- 23-87-110. Provisions of policies and certificates of insurance.
- 23-87-111. Delivery of policy or certificate.

SECTION.

- 23-87-112. Filing, approval, and withdrawal of policies, certificates, notices, etc.
- 23-87-113. Premiums and refunds.
- 23-87-114. Issuance of policies.
- 23-87-115. Claims.
- 23-87-116. Debtor's choice of insurer as additional security.
- 23-87-117. Compensation limited.
- 23-87-118. Enforcement.
- 23-87-119. Judicial review.

Cross References. Manner of payment of claims, §§ 23-63-106, 23-63-107.

Effective Dates. Acts 1973, No. 66, § 12: Feb. 6, 1973. Emergency clause provided: "It is hereby found and determined by the General Assembly that the laws of this state concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and that the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist, this Act being necessary for the public peace, health and safety, shall be in full force and effect from and after its passage and approval."

Acts 2003, No. 1794, § 7: Apr. 22, 2003. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that current Arkansas law regulating the purchase of credit life insurance and credit disability insurance does not provide adequate notice to insurance consumers and does not allow the Insurance Commissioner to adequately regulate the issuance of credit

life insurance and credit disability policies; that this act protects consumers by requiring certain notice to insurers, by granting to the Insurance Commissioner the exclusive jurisdiction to regulate the issuance of credit life and credit disability insurance policies and to approve credit life and credit disability insurance rates, and by clarifying the formula that may be used to determine refunds for reducing term credit life insurance or reducing credit disability insurance; and that this act is immediately necessary to protect consumers purchasing credit life insurance and credit disability insurance. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

RESEARCH REFERENCES

Am. Jur. 43 **Am. Jur. 2d, Ins.**, § 522.

23-87-101. Title.

This chapter may be cited as the “Model Act for the Regulation of Credit Life Insurance and Credit Disability Insurance”.

History. Acts 1959, No. 148, § 428;
A.S.A. 1947, § 66-3802.

23-87-102. Purpose.

The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit disability insurance.

History. Acts 1959, No. 148, § 427;
A.S.A. 1947, § 66-3801.

23-87-103. Definitions.

For the purpose of this chapter, unless the context otherwise requires:

(1) “Credit disability insurance” means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(2) “Credit life insurance” means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction for a period of time not to exceed ten (10) years;

(3) “Creditor” means the lender of money or vendor or lessor of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of the lender, vendor, or lessor;

(4) “Debtor” means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction; and

(5) “Indebtedness” means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

History. Acts 1959, No. 148, § 430;
1973, No. 66, § 9; A.S.A. 1947, § 66-3804.

CASE NOTES

Cited: Winkle v. Grand Nat’l Bank, 267 449 U.S. 880, 101 S. Ct. 230, 66 L. Ed. 2d Ark. 123, 601 S.W.2d 559, cert. denied, 104 (1980).

23-87-104. Scope.

All life insurance and all disability insurance sold in connection with loans or other credit transactions shall be subject to the provisions of this chapter, except insurance sold in connection with a loan or other credit transaction of more than ten (10) years’ duration.

History. Acts 1959, No. 148, § 429; 1973, No. 66, § 8; A.S.A. 1947, § 66-3803.

23-87-105. Construction.

(a) Nothing in this chapter is intended to prohibit or discourage reasonable competition.

(b) The provisions of this chapter shall be liberally construed.

History. Acts 1959, No. 148, § 427; A.S.A. 1947, § 66-3801.

23-87-106. Penalties.

(a) In addition to any penalty provided by law, any person who violates an order of the Insurance Commissioner after it has become final, and while the order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Arkansas a sum not to exceed two hundred fifty dollars (\$250) which may be recovered in a civil action. However, if violation is found to be willful, the amount of the penalty shall be a sum not to exceed one thousand dollars (\$1,000).

(b)(1) In the commissioner's discretion, the commissioner may also revoke or suspend the license or certificate of authority of the person guilty of any violation as set out in subsection (a) of this section.

(2) The order for suspension or revocation shall be subject to judicial review as provided in § 23-61-307.

History. Acts 1959, No. 148, §§ 444, 445; A.S.A. 1947, §§ 66-3818, 66-3819.

23-87-107. Policy forms.

Credit life insurance and credit disability insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan;

(2) Individual policies of disability insurance issued to debtors on a term plan, or disability provisions in individual life policies to provide coverage;

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and

(4) Group policies of disability insurance issued to creditors on a term plan insuring debtors, or disability provisions in group life policies to provide coverage.

History. Acts 1959, No. 148, § 431; A.S.A. 1947, § 66-3805.

23-87-108. Amount.

(a) CREDIT LIFE INSURANCE. The amount of credit life insurance shall not exceed the original amount of the indebtedness and any interest included therein.

(b) CREDIT DISABILITY INSURANCE. The amount of periodic indemnity payable by credit disability insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness and shall not exceed the original indebtedness and any interest included therein divided by the number of periodic installments.

History. Acts 1959, No. 148, § 432; A.S.A. 1947, § 66-3806; Acts 2003, No. 1794, § 1.

Amendments. The 2003 amendment added “and any interest included therein” in (a) and (b).

CASE NOTES

Credit Life Insurance.

Credit life insurance premiums paid to a lender for insurance could not be considered an interest. *Winkle v. Grand Nat’l Bank*, 267 Ark. 123, 601 S.W.2d 559, cert. denied, 449 U.S. 880, 101 S. Ct. 230, 66 L. Ed. 2d 104 (1980).

Where the total indebtedness of borrowers to bank on a credit transaction was

\$39,596.40 and maximum amount payable on credit life insurance policy was \$25,000, there was no violation of subsection (a) of this section. *Winkle v. Grand Nat’l Bank*, 267 Ark. 123, 601 S.W.2d 559, cert. denied, 449 U.S. 880, 101 S. Ct. 230, 66 L. Ed. 2d 104 (1980).

23-87-109. Term.

(a)(1) Subject to acceptance by the insurer, the term of any credit life insurance or credit disability insurance shall commence on the date when the debtor becomes obligated to the creditor.

(2) However, when a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to that indebtedness shall commence on the effective date of the policy.

(b) The term of the insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor.

(c) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness.

(d) In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in § 23-87-113.

History. Acts 1959, No. 148, § 433; A.S.A. 1947, § 66-3807.

23-87-110. Provisions of policies and certificates of insurance.

(a) All credit life insurance and credit disability insurance sold shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance. The individual policy or group certificate of insurance shall be delivered to the debtor.

(b) In addition to other requirements of law, each individual policy or group certificate of credit life insurance and credit disability insurance shall set forth the name and home office address of the insurer, the identity by name or otherwise of the person or persons insured, the rate or amount of payment, if any, by the debtor separately in connection with credit life insurance and credit disability insurance, and a description of the coverage, including any exceptions, limitations, or restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, whenever the amount of insurance may exceed the unpaid indebtedness, that any excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his or her estate.

(c)(1) An individual policy, group certificate of insurance for credit life insurance and credit disability insurance, or a related form or document delivered to the debtor shall fully disclose to the debtor that purchase of credit life insurance and credit disability insurance is voluntary and is not required as a condition for the extension of credit.

(2) A credit life insurance and credit disability insurance policy or related form or document shall be filed with and approved by the Insurance Commissioner before it may be used in this state.

(3)(A) The commissioner's approval of a credit life insurance and credit disability policy or related form or document shall be prima facie evidence that the language of the policy is not contrary to the Arkansas Insurance Code.

(B) There shall be no private cause of action challenging the validity or propriety of a policy or related form approved by the commissioner.

(C) Any action or process challenging or questioning the validity of a credit life insurance and credit disability policy or related form approved by the commissioner shall be brought only in the State Insurance Department under applicable provisions of the Arkansas Insurance Code or under procedures established by the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(d) The sale of credit life insurance or credit disability insurance shall not create a fiduciary relationship between the insurer and the insured.

(e) The insured's signature on an individual policy or group certificate of insurance of credit life insurance and credit disability insurance or a related document provided to the insured, evidencing the insured's election to purchase insurance in connection with a loan, shall be prima facie evidence of the insured's voluntary election to purchase the insurance.

History. Acts 1959, No. 148, § 434; A.S.A. 1947, § 66-3808; Acts 2003, No. 1794, § 2.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was

originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-74-306.

Amendments. The 2003 amendment added (c) through (e).

CASE NOTES

Distribution of Benefits.

It was appropriate for the court to take judicial notice that it was the customary practice of all credit life insurance companies, in the event of the death of the insured, to pay any amount of the insurance not needed to satisfy the outstanding

balance of the note involved to the secondary beneficiary or the estate of the insured. *Winkle v. Grand Nat'l Bank*, 267 Ark. 123, 601 S.W.2d 559, cert. denied, 449 U.S. 880, 101 S. Ct. 230, 66 L. Ed. 2d 104 (1980).

23-87-111. Delivery of policy or certificate.

(a) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in subsection (b) of this section.

(b)(1) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the amount of payment by the debtor separately in connection with credit life insurance and credit disability insurance coverage, and a brief description of the coverage provided or to be provided shall be delivered to the debtor at the time the indebtedness is incurred.

(2) The copy of the application for or notice of proposed insurance shall refer exclusively to insurance coverage and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement unless the information required by this section is prominently set forth therein.

(3) Upon approval of the application, if any, or acceptance of the insurance and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor.

(4) The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as of the date the indebtedness is incurred.

(5) The insurer may rely upon the representations in the application regarding the health and employment of the applicant without further investigation or examination of the debtor.

(6) If credit life insurance or credit disability insurance is rescinded due to material misrepresentation on the part of the insured, the insured shall be entitled to a full refund of the premium paid.

History. Acts 1959, No. 148, § 435; A.S.A. 1947, § 66-3809; Acts 2003, No. 1794, § 3.
Amendments. The 2003 amendment added (b)(5) and (6).

23-87-112. Filing, approval, and withdrawal of policies, certificates, notices, etc.

(a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, binders, endorsements, and riders shall be filed with the insurance commissioner in the state in which the policy is issued.

(b) Within thirty (30) days after the filing of all policies, certificates of insurance, notices of proposed insurance, applications for insurance, binders, endorsements, and riders, in addition to other requirements of law, the commissioner may disapprove the form if the table of premium rates charged or to be charged appears by reasonable assumptions to be excessive in relation to benefits or if it contains provisions that are unjust, unfair, inequitable, misleading, or deceptive or encourage misrepresentation of the policy.

(c)(1) If the commissioner notifies the insurer that the form does not comply with this section, it is unlawful thereafter for the insurer to issue or use the form.

(2) In the notice, the commissioner shall specify the reason for his or her disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer.

(3) No policy, certificate of insurance, notice of proposed insurance and no application, binder, endorsement, or rider shall be issued or used until the expiration of thirty (30) days after it has been so filed unless the commissioner gives his or her prior written approval thereto.

(d) At any time after a hearing, of which not less than twenty (20) days' written notice was given to the insurer, the commissioner may withdraw his or her approval of any form on any such grounds.

(e) It is not lawful for the insurer to issue the forms or use them after the effective date of the withdrawal of approval.

(f) Any order or final determination of the commissioner under the provisions of this section shall be subject to judicial review.

History. Acts 1959, No. 148, § 436; A.S.A. 1947, § 66-3810; Acts 2003, No. 1794, § 4.
Amendments. The 2003 amendment substituted "commissioner" for "Insurance Commissioner" in (b).

23-87-113. Premiums and refunds.

(a)(1) Each insurer issuing credit life insurance or credit disability insurance shall file with the Insurance Commissioner its schedules of premium rates for use in connection with the insurance.

(2) Any insurer may revise the schedule from time to time and shall file the revised schedules with the commissioner.

(3) No insurer shall issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that

determined by the schedules of the insurer as then on file with the commissioner.

(4) The commissioner may require the filing of the schedule of premium rates for use in connection with and as a part of the specific policy filings as provided by § 23-87-112.

(5)(A) The commissioner shall have exclusive jurisdiction to approve all credit life insurance and credit disability insurance rates, policies, group certificates of insurance and related notices, applications, binders, endorsements, and riders issued in this state.

(B) Rates regarding credit life insurance or credit disability insurance that have been promulgated or approved by the commissioner are deemed to be valid unless changed under the Arkansas Insurance Code or the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(C)(1) There shall be no private cause of action for challenging credit life insurance or credit disability insurance rates that have been promulgated or approved by the commissioner.

(2) Any action or process challenging or questioning the validity of credit life insurance and credit disability rates approved by the commissioner shall be brought only in the State Insurance Department under applicable provisions of the Arkansas Insurance Code or under procedures established by the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b)(1) Each individual policy, group certificate, or notice of proposed issuance of credit life insurance and credit disability insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of premium due shall be paid or credited promptly to the person entitled thereto. However, the commissioner shall prescribe a minimum refund, and no refund that would be less than the minimum need be made.

(2)(A) The formula to be used in computing refunds shall be filed with the commissioner.

(B) The Rule of 78s is a permissible method of computing refunds for reducing term credit life insurance or reducing credit disability insurance on which the insurance charges to the debtor are paid in a single sum.

(C) The formula used for computing refunds shall be disclosed in the policy or group certificate of insurance.

(3)(A) The commissioner shall have the exclusive jurisdiction to promulgate or approve methods of computing refunds of unearned premiums.

(B) Any formula or method used or approved by the commissioner for determining the return of unearned premium under this section shall be deemed to be fair and reasonable.

(C)(i) There shall be no private cause of action to challenge any method of refunding unearned premium that has been promulgated or approved by the commissioner under this section.

(ii) Any action or process challenging or questioning the method of refunding an unearned credit life insurance and credit disability

premium that has been approved by the commissioner shall be brought only in the department under applicable provisions of the Arkansas Insurance Code or under procedures established by the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(c) If a creditor requires a debtor to make a payment in connection with credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

History. Acts 1959, No. 148, § 437; A.S.A. 1947, § 66-3811; Acts 2003, No. 1794, § 5.

A.C.R.C. Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148.

Acts 1959, No. 148 is codified as set out in the note following § 23-74-306.

Amendments. The 2003 amendment added (a)(5); inserted the subdivision (b)(1) and (b)(2)(A) designations; and added (b)(2)(B), (b)(2)(C) and (b)(3).

23-87-114. Issuance of policies.

All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein and shall be issued only through holders of licenses issued by the Insurance Commissioner.

History. Acts 1959, No. 148, § 438; A.S.A. 1947, § 66-3812.

23-87-115. Claims.

(a) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid by check or draft of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of the claimant, to one specified.

(c) No plan or arrangement shall be used whereby any person, firm, or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims, except that a group policyholder, by arrangement with the group insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History. Acts 1959, No. 148, § 439; 1983, No. 477, § 1; A.S.A. 1947, § 66-3813.

23-87-116. Debtor's choice of insurer as additional security.

When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor shall, upon

request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or her or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

History. Acts 1959, No. 148, § 440; A.S.A. 1947, § 66-3814.

23-87-117. Compensation limited.

(a)(1) In order to assure that the premium rates charged or to be charged for credit life or credit disability insurance are reasonable in relation to benefits provided, the Insurance Commissioner, after due notice and hearing, may issue rules and regulations establishing the maximum compensation payable to an agent, a broker, or a creditor or any affiliate, associate, subsidiary, director, officer, employee, or other representative of or for the creditor for writing or handling the insurance, including commission, dividends, premium adjustments, policy writing fees, underwriting gain, or any compensation or remuneration in whatever form.

(2) An insurer may disclose the amount of commission or compensation payable to an agent, broker, or creditor under this section.

(b) Provided, the term “compensation” as defined and used in this section shall not be deemed to include reinsurance premiums paid to, or underwriting profits generated by, an insurer or reinsurer owned by, controlled by, or under common control with a credit insurer, an agent, broker, creditor, group of creditors, or any affiliate, associate, subsidiary, director, officer, employee, or other representative of, or for such a credit insurer, creditor, or group of creditors, on accounts in existence with such an insurer or reinsurer on January 17, 1989, that have been registered with the commissioner within twenty (20) days of July 3, 1989, in accordance with pertinent rules and regulations promulgated by the commissioner.

(c) Provided further, any and all payments to all direct and indirect successors in interests whether through purchase, gift, devise, or otherwise, related to all accounts registered under this section shall also not be deemed compensation.

History. Acts 1959, No. 148, § 441; 1985, No. 950, § 1; A.S.A. 1947, § 66-3815; Acts 1989, No. 177, § 1; 1989, No. 843, § 1; 2003, No. 1794, § 6.

Amendments. The 2003 amendment inserted the subdivision (a)(1) designation and added (a)(2).

23-87-118. Enforcement.

(a) After notice and hearing, the Insurance Commissioner may issue such rules and regulations as the commissioner deems appropriate for the supervision of this chapter.

(b)(1) Whenever the commissioner finds that there has been a violation of this chapter or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person licensed by the commissioner, the commissioner shall set forth the details of his or her findings together with an order for compliance by a specified date.

(2) The order shall be binding on the insurer and other person licensed by the commissioner on the date specified unless sooner withdrawn by the commissioner or a stay thereof has been ordered by a court of competent jurisdiction.

History. Acts 1959, No. 148, § 442;
A.S.A. 1947, § 66-3816.

23-87-119. Judicial review.

Any party to the proceeding affected by an order of the Insurance Commissioner shall be entitled to judicial review by following the procedure set forth in § 23-61-307.

History. Acts 1959, No. 148, § 443;
A.S.A. 1947, § 66-3817.

Index to Title 23 (74--87)

A

ACCIDENT INSURANCE.

Credit life and disability insurance,
§§23-87-101 to 23-87-119.

See CREDIT LIFE AND DISABILITY
INSURANCE.

Group accident insurance.

Impairment of speech or hearing,
§23-79-130.

ACTIONS.

Fraternal benefit societies.

Indemnification or reimbursement of
persons threatened by, §23-74-203.

Insurance.

See INSURANCE.

Viatical settlements.

Civil remedies, §23-81-613.

ADMINISTRATIVE PROCEDURE.

Health maintenance organizations.

Proceedings, §23-76-126.

Medicare supplement insurance policy provisions.

Applicability of act, §23-79-409.

ADOPTION.

Health insurance.

Coverage for adopted minors,
§23-79-137.

ADVERTISING.

Health maintenance organizations.

Untrue or misleading advertising.
Prohibited practices, §23-76-119.

Medicare supplement insurance policies.

Filing requirements, §23-79-408.

Viatical settlements, §23-81-611.

AGE.

Fraternal benefit societies.

Membership.
Adult membership.
Minimum age, §23-74-201.

AGENTS.

Automobile clubs or associations,
§23-77-108.

Health maintenance organizations.
Regulation, §23-76-120.

ALCOHOLIC BEVERAGES.

Insurance.

Care and treatment of alcohol and
drug dependency.
Insurers transacting health,
accident or disability insurance
in state.
Requirements of group policies,
contracts and plans providing
hospital and medical
coverage, §23-79-139.
Health insurance.
Policy provisions, §23-85-126.

AMBULANCES.

Insurance.

Direct reimbursement for ambulance
services, §23-79-148.

ANNUITIES.

Fraternal benefit societies.

Contractual benefits provided by
societies.
Annuity benefits, §23-74-401.

Insurance.

General provisions.
See INSURANCE.

APPEALS.

Fraternal benefit societies.

Decisions and findings of
commissioner of insurance.
Review of, §23-74-702.

Hospital and medical service corporations.

Review of decisions, §23-75-118.

Insurance.

Burial associations.
Revocation of certificates of
authority, §§23-78-124,
23-78-125.
Credit life and disability insurance.
Parties aggrieved by decisions of
commissioner, §23-87-119.
Policies.
Commercial property and casualty
insurance policies.
Appeals from orders of
commissioner, §23-79-309.

ASSESSMENTS.

**Comprehensive health insurance
pool,** §23-79-507.
Maximum amount, §23-79-508.

ASSESSMENTS —Cont'd**Insurance.**

- Burial associations.
- Membership dues and assessments, §23-78-116.

ASSETS.**Fraternal benefit societies.**

- Held, invested and disbursed for use and benefit of society, §23-74-502.

ASSIGNMENTS.**Fraternal benefit societies.**

- Benefit contracts, §23-74-404.

Insurance.

- Policies, §23-79-124.

ASSOCIATIONS.**Automobile clubs or associations,**

- §§23-77-101 to 23-77-109.

See AUTOMOBILE CLUBS OR ASSOCIATIONS.

Burial associations.

- Insurance, §§23-78-101 to 23-78-125.
- See BURIAL INSURANCE ASSOCIATIONS.

Motor vehicles.

- Automobile clubs or associations, §§23-77-101 to 23-77-109.
- See AUTOMOBILE CLUBS OR ASSOCIATIONS.

ATTACHMENT.**Fraternal benefit societies.**

- Benefits not attachable, §23-74-403.

ATTORNEY GENERAL.**Fraternal benefit societies.**

- Domestic societies.
- Injunctions.
 - Commencing action, §23-74-606.
- Injunctions.
 - Recognition of proceedings.
 - Application or petition made by attorney general upon request of commissioner, §23-74-608.

ATTORNEYS AT LAW.**Insurance.**

- Actions.
 - Suits against insurers.
 - Damages and attorney's fees on loss claims, §23-79-208.

ATTORNEYS' FEES.**Insurance claims.**

- Suits against insurers, §23-79-208.
- Allowance of attorney's fees in suits to terminate, modify or reinstate policies, §23-79-209.

AUTOMOBILE CLUBS OR ASSOCIATIONS.**Agent.**

- License.
 - Fee, §23-77-108.

Certificates of authority.

- Applications, §23-77-106.
- Fees, §23-77-106.
- Issuance, §23-77-106.
- Power to grant, §23-77-105.
- Required, §23-77-106.
- Suspension or revocation, §23-77-107.

Definitions, §23-77-101.**Exclusive authority for operation of clubs and associations, §23-77-102.****Fees.**

- Agents.
 - Annual license fee, §23-77-108.
 - Certificates of authority, §23-77-106.

Financial reporting, §23-77-106.**Hearings.**

- Insurance commissioner may conduct hearings, §23-77-105.
- Suspension or revocation of certificate, §23-77-107.

Insurance commissioner.

- Information.
 - Duty to provide, §23-77-109.
- Powers, §23-77-104, 23-77-105.

Licenses.

- Agents, §23-77-108.

Misdemeanors.

- Violations of provisions, §23-77-103.

Penalties.

- Violations of provisions, §23-77-103.

Registered agent.

- Service of process, §23-77-106.

Reports.

- Annual report, §23-77-109.
- Financial reporting, §23-77-106.

Rules and regulations.

- Insurance commissioner, §23-77-105.
- Violations of rules.
 - Penalties, §23-77-103.

Service of process, §23-77-106.**Violations of provisions.**

- Penalties, §23-77-103.

AUTOPSIES.**Health insurance.**

- Policy provisions, §23-85-115.

B**BONDS, SURETY.****Fraternal benefit societies.**

- Articles of incorporation.
- Applicants for incorporation, §23-74-301.

BONDS, SURETY —Cont'd**Health maintenance organizations.**

Directors, officers or partners,
§23-76-111.

Insurance.

Burial associations.
Board.
Executive secretary, §23-78-107.

BREAST CANCER.**Mammography.**

Definitions, §23-79-140.
Insurance coverage, §23-79-140.

BURIAL INSURANCE ASSOCIATIONS.**Agent's license.**

Fee, §23-78-113.
Renewal, §23-78-113.

Applicability of provisions.

Existing associations subject to
chapter, §23-78-102.

Assessments, §23-78-116.**Authority of act, §23-78-103.****Board.**

Appointment of members, §23-78-105.
Burial associations under control of
board, §23-78-109.
Chairman, §23-78-106.
Composition, §23-78-105.
Consumer representative, §23-78-106.
Creation, §23-78-105.
Duties, §23-78-108.
Employees, §23-78-107.
Executive secretary, §23-78-107.
Bond, surety, §23-78-107.
Expenses of members, §23-78-105.
Legal counsel, §23-78-107.
Meetings, §23-78-106.
Oath of office, §23-78-105.
Powers, §23-78-108.

Burial associations under control of
board, §23-78-109.

Qualifications of members, §23-78-105.
Quorum, §23-78-106.
Removal of members, §23-78-105.
Terms of members, §23-78-105.
Vacancies, §23-78-105.

Bonds, surety.

Board.
Executive secretary, §23-78-107.

Books and records.

Failure to maintain, §23-78-119.
Inspection and audit, §23-78-117.

Bylaws, §23-78-115.**Certificates for benefits.**

Issuance, §23-78-112.

Certificates of authority.

Application, §23-78-110.
Issuance, §23-78-110.

BURIAL INSURANCE**ASSOCIATIONS —Cont'd****Certificates of authority —Cont'd**

Revocation, §23-78-124.
Appeals, §23-78-125.
Hearings, §23-78-124.

Chapter exclusive authority, §23-78-103.**Definitions, §23-78-101.****Disposition of collections, §23-78-122.****Disposition of fees and charges, §23-78-123.****Existing associations subject to chapter, §23-78-102.****False claims, promises or representations of agent, §23-78-114.****False entries, §23-78-118.****Fees, §23-78-111.**

Disposition, §23-78-123.

Hearings.

Decisions, §23-78-108.
Power to conduct, §23-78-108.
Revocation of certificates of authority,
§23-78-124.
Witnesses, §23-78-108.

Investments.

Collections, §23-78-122.

Membership dues, §23-78-116.**Oaths.**

Board.
Oath of office, §23-78-105.
Fees.
Oath at payment, §23-78-111.

Penalties.

Violations, §23-78-104.

Records.

Failure to maintain, §23-78-119.
Inspection and audit, §23-78-117.

Reports.

Semiannual reports, §23-78-120.

Rules and regulations, §§23-78-115, 23-78-121.**Violations.**

Penalties, §23-78-104.

BURIALS.**Insurance.**

Associations, §§23-78-101 to 23-78-125.
See BURIAL INSURANCE
ASSOCIATIONS.

C**CANCER.****Breast cancer.****Mammography.**

Coverage for mammogram screening
of occult breast cancer,
§23-79-140.

CANCER —Cont'd**Breast cancer —Cont'd****Mammography —Cont'd**

Definitions, §§23-79-140.

Insurance.

Coverage, §23-79-140.

Definitions, §23-79-112.

Definitions.

Mammography, §23-79-140.

Health maintenance organizations.

Mammogram screening of occult breast cancer.

Coverage generally, §23-79-140.

Hospital and medical service corporations.

Mammogram screening of occult breast cancer.

Coverage generally, §23-79-140.

Insurance.

Mammograms.

Coverage for mammogram screening of occult breast cancer.

Generally, §23-79-140.

Definitions, §23-79-112.

Prescription medication.

Coverage, §23-79-147.

CASUALTY INSURANCE.**Policies.**

Commercial property and casualty insurance policies, §§23-79-301 to 23-79-310.

Administrative procedures, §23-79-309.

Appeals, §23-79-309.

Applicability of provisions, §23-79-303.

Claims-made policy.

Defined, §23-79-302.

Construction of provisions, §23-79-304.

Minimum standards, §§23-79-301 to 23-79-310.

Motor vehicle coverage.

Extraterritorial provisions, §23-79-311.

Stepdowns, §23-79-312.

Noncomplying provisions, §23-79-308.

Punitive damages exclusion, §23-79-307.

Purpose, §23-79-301.

Renewal, §23-79-307.

Requirements, §23-79-306.

Rules and regulations, §23-79-310.

Standards, §23-79-307.

Violations, §23-79-305.

CASUALTY INSURANCE —Cont'd**Policies —Cont'd**

Property and casualty insurance policy simplification, §§23-80-301 to 23-80-308.

Applicability, §23-80-304.

Citation of act, §23-80-301.

Commissioners' powers, §23-80-305.

Compliance by provision of outline of coverage, §23-80-308.

Compliance with other statutorily required language, §23-80-307.

Minimum standards, §23-80-306.

Policy or policy forms defined, §23-80-303.

Purpose, §23-80-302.

Policy simplification.

Applicability, §23-80-304.

Citation of act, §23-80-301.

Compliance by provision of outline of coverage, §23-80-308.

Compliance with other statutorily required language, §23-80-307.

Minimum standards, §23-80-306.

Policy or policy forms.

Defined, §23-80-303.

Powers of commissioner, §23-80-305.

Purpose, §23-80-302.

CEASE AND DESIST ORDERS.**Viatical settlements.**

Civil remedies, §23-81-613.

CEMETERIES.**Burials.**

Associations.

Insurance, §§23-78-101 to 23-78-125.

See BURIAL INSURANCE ASSOCIATIONS.

CHARITIES.**Hospital and medical service corporations.**

Donations.

Power to make donations for the public welfare, §23-75-121.

CLAIMS.**Health maintenance organizations.**

Complaint system, §23-76-116.

Insurance.

See INSURANCE.

CLUBS.**Automobile clubs or associations,**

§§23-77-101 to 23-77-109.

See AUTOMOBILE CLUBS OR ASSOCIATIONS.

COMPREHENSIVE HEALTH**INSURANCE POOL, §§23-79-501 to 23-79-510.****Assessments, §23-79-507.**

COMPREHENSIVE HEALTH INSURANCE POOL —Cont'd

Benefits.

Outline of benefits, §23-79-510.

Board of directors, §23-79-504.

Plan of operation, §23-79-505.

Citation of act.

Short title, §23-79-502.

Collective action.

Immunity from liability, §23-79-512.

Confidentiality of information, §23-79-511.

Coverage under plan.

Benefits, §23-79-510.

Eligibility, §23-79-509.

Policy renewal, §23-79-510.

Creation, §23-79-504.

Definitions, §23-79-503.

Eligibility, §23-79-509.

Funding of pool, §23-79-507.

Immunity.

Board not liable for obligations of pool, §23-79-504.

Collective actions, §23-79-512.

Insurers.

Assessments, §23-79-507.

Defined, §23-79-503.

Participation in pool, §23-79-504.

Plan.

Coverage under.

Policy renewal, §23-79-510.

Defined, §23-79-503.

Plan administrator, §23-79-508.

Plan of operation, §23-79-505.

Powers, §23-79-506.

Premiums.

Funding of pool, §23-79-507.

Purpose, §23-79-501.

Reciprocal agreements, power to enter into, §23-79-506.

Study by legislature, §23-79-514.

Title of act.

Short title, §23-79-502.

Unfair competition and trade practices.

Unfair referrals to plan, §23-79-513.

CONFIDENTIALITY OF INFORMATION.

Comprehensive health insurance pool, §23-79-511.

Health insurance.

Portability and accountability.

Disclosure of information by health plan issuers, §23-86-313.

Health maintenance organizations.

Filings and reports as public documents, §23-76-128.

CONFIDENTIALITY OF INFORMATION —Cont'd

Health maintenance organizations —Cont'd

Medical information, §23-76-129.

Insurance.

Group and blanket health insurance.

Mental health coverage, §23-86-113.

Viatical settlements.

Fraud prevention and control, §23-81-612.

CONFLICTS OF INTEREST.

Health insurance.

Small employer health insurance purchasing groups, §23-86-508.

Viatical settlements.

Examiners, §23-81-607.

CONSENT.

Viatical settlements.

Contract prerequisites, §23-81-609.

CONSOLIDATION.

Fraternal benefit societies, §23-74-305.

CONSUMER CHOICE IN HEALTH INSURANCE, §§23-79-801 to 23-79-805.

CONSUMER PROTECTION.

Health insurance.

Consumer choice in health insurance, §§23-79-801 to 23-79-805.

CONTRACTS.

Fraternal benefit societies.

Benefit contracts.

See FRATERNAL BENEFIT SOCIETIES.

Consolidation or merger, §23-74-305.

Health maintenance organizations.

Authority to contract.

Director of the department of health, §23-76-130.

Hold harmless clauses.

Protection against insolvency, §23-76-118.

Hospital and medical service corporations.

Subscription contracts, §23-75-111.

Viatical settlements.

Prerequisites to contract, §23-81-609.

Prohibited contracts, §23-81-610.

CONTROLLED SUBSTANCES.

Insurance.

Health insurance.

Policy provisions, §23-85-126.

CORPORATIONS.

Burial associations.

Insurance, §§23-78-101 to 23-78-125.

See BURIAL INSURANCE ASSOCIATIONS.

COUNSELORS.**Health insurance.**

- Group and blanket health insurance.
- Mental health coverage, §23-86-113.

COUNTIES.**Insurance.**

- Direct actions against insurer, §23-79-210.

CRANIOMANDIBULAR DISORDER.**Health insurance.**

- Optional coverage to be offered, §23-79-150.

Health maintenance organizations.

- Optional coverage to be offered, §23-79-150.

Hospital or medical services corporations.

- Optional coverage to be offered, §23-79-150.

CREDIT LIFE AND DISABILITY INSURANCE, §§23-87-101 to 23-87-119.**Amounts of insurance authorized, §23-87-108.****Appeals.**

- Parties aggrieved by decisions of commissioner, §23-87-119.

Certificates.**Forms.**

- Filing, approval and withdrawal of forms, §23-87-112.

Policies.

- Delivery of policy or certificate, §23-87-111.

- Provisions of policies and certificates.

- Disclosure to debtors, §23-87-110.

Citation of chapter, §23-87-101.**Claims.**

- Reporting, §23-87-115.

Compensation.

- Limitations, §23-87-117.

Construction and interpretation, §23-87-105.**Definitions, §23-87-103.****Enforcement of provisions, §23-87-118.****Forms.****Policies.**

- Filing, approval and withdrawal of forms, §23-87-112.

Issuance of policies, §23-87-114.**Judicial review, §23-87-119.****Legislative declaration.**

- Purpose of provisions, §23-87-102.

Penalties.

- Violations, §23-87-106.

CREDIT LIFE AND DISABILITY INSURANCE —Cont'd**Policies.**

- Amounts of insurance authorized, §23-87-108.

Certificates.

- Delivery of policy or certificate, §23-87-111.

- Disclosure of provisions to debtors, §23-87-110.

Compensation.

- Limitations, §23-87-117.

Delivery, §23-87-111.**Enforcement of provisions, §23-87-118.****Existing insurance.**

- Choice of insurer, §23-87-116.

Forms.

- Filing, approval and withdrawal, §23-87-112.

Issuance, §23-87-114.

- Allowable forms, §23-87-107.

Penalties for violations, §23-87-106.**Premiums.**

- Schedules of premium rates, §23-87-113.

Provisions required.

- Disclosure to debtors, §23-87-110.

Terms of insurance, §23-87-109.**Premiums.**

- Schedule of premium rates, §23-87-113.

Purpose of provisions, §23-87-102.**Rates.**

- Schedule, §23-87-113.

Refunds, §23-87-113.**Reports.**

- Claims, §23-87-115.

Scope of chapter, §23-87-104.**Short title, §23-87-101.****Terms of insurance, §23-87-109.****CREDIT UNIONS.****Insurance.**

- Group annuities and group life insurance, §23-83-105.

CRIMINAL LAW AND PROCEDURE.**Automobile clubs or associations, §23-77-103.****Burial associations.**

- Failure to comply with provisions, §23-78-104.

- False claim, promise or representation of agent, §23-78-114.

- False entries in books, §23-78-118.

- False statements, §23-78-111.

Fraternal benefit societies.

- Fraudulent statements or solicitations of membership, §23-74-703.

CRIMINAL LAW AND PROCEDURE

—Cont'd

Health maintenance organizations,
§23-76-105.

Viatical settlements, §23-81-613.

D**DEATH.****Fraternal benefit societies.**

Contractual benefits provided by
societies.

Death benefits, §23-74-401.

DEFENSES.**Insurance.**

Health insurance.

Time limit on certain defenses,
§23-85-107.

DEFINED TERMS.**Actuarial certification.**

Small employer health insurance,
§23-86-202.

Advertising.

Viatical settlements, §23-81-602.

Affiliation period.

Health insurance portability and
accountability, §23-86-303.

Agent.

Comprehensive health insurance pool,
§23-79-503.

Health maintenance organizations,
§23-76-120.

**Aggregate individually underwritten
policy experience.**

Health insurance, group, conversion
policies, §23-86-115.

**Alcohol or drug dependency
treatment facility.**

Insurance policies, §23-79-139.

Applicant.

Medicare supplement insurance
minimum standards, §23-79-403.

Automobile club or association,
§23-77-101.**Bail bond service.**

Automobile clubs or associations,
§23-77-101.

Base premium rate.

Small employer health insurance,
§23-86-202.

Benefit contract.

Fraternal benefit societies, §23-74-104.

Benefit level.

Freedom of choice among health
benefit plans, §23-86-406.

Benefit member.

Fraternal benefit societies, §23-74-104.

DEFINED TERMS —Cont'd**Blanket accident and health
insurance.**

Group and blanket health insurance,
§23-86-101.

Bona fide association.

Health insurance portability and
accountability, §23-86-303.

Burial association, §23-78-101.**Business of viatical settlements,**
§23-81-602.**Buying and selling service.**

Automobile clubs or associations,
§23-77-101.

Carrier.

Small employer health insurance,
§23-86-202.

Case characteristics.

Small employer health insurance,
§23-86-202.

Casualty insurance.

Insurance policies.
Simplification, §23-80-303.

Certificate.

Fraternal benefit societies, §23-74-104.

Medicare supplement insurance
minimum standards, §23-79-403.

Certificate form.

Medicare supplement insurance
minimum standards, §23-79-403.

Chemotherapy.

Health insurance, outpatient coverage,
§23-85-133.

Chronically ill.

Viatical settlements, §23-81-602.

Church plan.

Comprehensive health insurance pool,
§23-79-503.

Health insurance portability and
accountability, §23-86-303.

Claims-made policy.

Insurance policies.
Commercial property and casualty
insurance, §23-79-302.

Class.

Health insurance, group, conversion
policies, §23-86-115.

Class of business.

Small employer health insurance,
§23-86-202.

COBRA continuation provision.

Health insurance portability and
accountability, §23-86-303.

Company.

Simplification of insurance policies,
§23-80-203.

Compensation.

Credit life and disability insurance,
§23-87-117.

DEFINED TERMS —Cont'd**Continuation coverage.**

Comprehensive health insurance pool,
§23-79-503.

Covered health care services.

Freedom of choice among health
benefit plans, §23-86-406.

Covered person.

Comprehensive health insurance pool,
§23-79-503.

Freedom of choice among health
benefit plans, §23-86-406.

Prescription drug card uniformity,
§23-80-402.

Creditable coverage.

Comprehensive health insurance pool,
§23-79-503.

Health insurance portability and
accountability, §23-86-303.

Credit life and disability insurance,
§23-87-103.**Credit life insurance,** §23-87-103.**Creditor.**

Credit life and disability insurance,
§23-87-103.

Debtor.

Credit life and disability insurance,
§23-87-103.

Dependent.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Diabetes self-management training.

Insurance coverage, §23-79-601.

Diagnostic mammography.

Insurance policies, §23-79-140.

Direct reimbursement.

Insurance coverage for ambulance
services, §23-79-148.

Discount service.

Automobile clubs or associations,
§23-77-101.

Divisible surplus.

Life insurance policies and annuities,
§23-81-108.

Domestic corporation.

Health maintenance organizations,
§23-76-102.

Eligible employee.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Eligible employer.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Eligible individual.

Health insurance portability and
accountability, §23-86-303.

DEFINED TERMS —Cont'd**Emergency road service.**

Automobile clubs or associations,
§23-77-101.

Employee.

Health insurance, franchise plan,
§23-85-101.

Health insurance, group accident and
health insurance, §23-86-106.

Health insurance portability and
accountability, §23-86-303.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Hospital and medical service
corporations, §23-75-104.

Employer.

Health insurance portability and
accountability, §23-86-303.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Employer contribution rule.

Health insurance portability and
accountability, §23-86-303.

Enrollee.

Health maintenance organizations,
§23-76-102.

Enrollment date.

Health insurance portability and
accountability, §23-86-303.

Evidence of coverage.

Health maintenance organizations,
§23-76-102.

Excepted benefits.

Health insurance portability and
accountability, §23-86-310.

Excess or stop loss coverage.

Comprehensive health insurance pool,
§23-79-503.

Experience period.

Insurance policies, §23-79-110.

Federal governmental plan.

Health insurance portability and
accountability, §23-86-303.

Federally eligible individual.

Comprehensive health insurance pool,
§23-79-503.

Financial services.

Automobile clubs or associations,
§23-77-101.

Financing entity.

Viatical settlements, §23-81-602.

Format.

Medicare supplement insurance
minimum standards, §23-79-406.

Fraternal benefit society, §23-74-101.

DEFINED TERMS —Cont'd

Fraudulent viatical settlement act,
§23-81-602.

Full time.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Governmental plan.

Comprehensive health insurance pool,
§23-79-503.

Health insurance portability and
accountability, §23-86-303.

Group accident and health insurance, §23-86-106.**Group health insurance coverage.**

Health insurance portability and
accountability, §23-86-303.

Group health plan.

Comprehensive health insurance pool,
§23-79-503.

Health insurance portability and
accountability, §23-86-303.

Group participation rule.

Health insurance portability and
accountability, §23-86-303.

Health benefit plan.

Freedom of choice among health
benefit plans, §23-86-406.

Health insurance consumer choice,
§23-79-802.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Prescription drug card uniformity,
§23-80-402.

Small employer health insurance,
§23-86-202.

Health care insurer.

Diabetes coverage, §23-79-601.

Health care plan.

Health maintenance organizations,
§23-76-102.

Insurance, temporomandibular joint
disorder and craniomandibular
disorder coverage, §23-79-150.

Health care provider.

Freedom of choice among health
benefit plans, §23-86-406.

Health care services.

Health maintenance organizations,
§23-76-102.

Tax credits for medically necessary
foods, §23-79-701.

Health carrier.

Insurance, temporomandibular joint
disorder and craniomandibular
disorder coverage, §23-79-150.

DEFINED TERMS —Cont'd**Health insurance.**

Comprehensive health insurance pool,
§23-79-503.

Health insurance coverage.

Health insurance portability and
accountability, §23-86-303.

Health insurance issuer.

Health insurance portability and
accountability, §23-86-303.

Health insurance policy.

Diabetes coverage, §23-79-601.

Health insurance purchasing group.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Health insurance purchasing group health carrier.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Health insurer.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Health maintenance organization,
§23-76-102.

Comprehensive health insurance pool,
§23-79-503.

Health insurance portability and
accountability, §23-86-303.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Health plan.

Tax credits for medically necessary
foods, §23-79-701.

Health professional.

Health maintenance organizations,
§23-76-102.

Health status-related factor.

Health insurance portability and
accountability, §23-86-303.

Hospital.

Comprehensive health insurance pool,
§23-79-503.

Hospital and medical service corporations, §23-75-101.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Indebtedness.

Credit life and disability insurance,
§23-87-103.

Index rate.

Small employer health insurance,
§23-86-202.

DEFINED TERMS —Cont'd**Individual health insurance coverage.**

Comprehensive health insurance pool,
§23-79-503.

Individual markets.

Health insurance portability and
accountability, §23-86-303.

Inherited metabolic disease.

Tax credits for medically necessary
foods, §23-79-701.

Insurable interest.

Personal insurance, §23-79-103.
Property, §23-79-104.

Insurance policy.

Cancer prescription medication,
§23-79-147.
Prescription drug benefits, §23-79-149.

Insurance service.

Automobile clubs or associations,
§23-77-101.

Insurer.

Comprehensive health insurance pool,
§23-79-503.
Simplification of insurance policies,
§23-80-203.

Issuer.

Medicare supplement insurance
minimum standards, §23-79-403.

Laboratory and pathological tests.

Health insurance, outpatient coverage,
§23-85-133.

Large employer.

Health insurance portability and
accountability, §23-86-303.

Large group.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Large-group market.

Health insurance portability and
accountability, §23-86-303.

Late enrollee.

Health insurance portability and
accountability, §23-86-303.

Law.

Fraternal benefit society, §23-74-104.

Legal service.

Automobile clubs or associations,
§23-77-101.

Limited network plan.

Freedom of choice among health
benefit plans, §23-86-406.

Lodge.

Fraternal benefit societies, §23-74-104.

Loss or impairment of speech or hearing.

Insurance policies, §23-79-130.

DEFINED TERMS —Cont'd**Loss ratio.**

Insurance policies, §23-79-110.

Low protein modified food product.

Tax credits for medically necessary
foods, §23-79-701.

Mammography.

Insurance policies, §23-79-140.

Map service.

Automobile clubs or associations,
§23-77-101.

Medical assistance.

Comprehensive health insurance pool,
§23-79-503.

Medical care.

Health insurance portability and
accountability, §23-86-303.

Medical food.

Tax credits for medically necessary
foods, §23-79-701.

Medical literature.

Insurance coverage for cancer
prescription medication,
§23-79-147.

Medically necessary.

Comprehensive health insurance pool,
§23-79-503.

Medical service corporations,

§23-75-101.

Medicare.

Comprehensive health insurance pool,
§23-79-503.

Medicare supplement policy.

Insurance policies, §23-79-403.

Member.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Motor club service.

Automobile clubs or associations,
§23-77-101.

Network plan.

Health insurance portability and
accountability, §23-86-303.

New business premium rate.

Small employer health insurance,
§23-86-202.

Nonfederal governmental plan.

Health insurance portability and
accountability, §23-86-303.

Partial hospitalization.

Health insurance, group, mental
health coverage, §23-86-113.

Participant.

Health insurance portability and
accountability, §23-86-303.

Participating provider.

Health maintenance organizations,
§§23-76-118, 23-76-119.

DEFINED TERMS —Cont'd**Periodic physical examinations.**

Insurance policies.

Children's preventive health care,
§23-79-141.

Person.

Health maintenance organizations,
§23-76-102.

Viatical settlements, §23-81-602.

Physician.

Comprehensive health insurance pool,
§23-79-503.

Placement.

Health insurance portability and
accountability, §23-86-303.

Plan.

Comprehensive health insurance pool,
§23-79-503.

Plan administrator.

Comprehensive health insurance pool,
§23-79-503.

Plan of operation.

Comprehensive health insurance pool,
§23-79-503.

Plan sponsor.

Health insurance portability and
accountability, §23-86-303.

Point-of-service.

Health maintenance organizations,
§23-76-109.

Point of service plan.

Freedom of choice among health
benefit plans, §23-86-406.

Policy.

Insurance policies, §23-79-101.

Life insurance policies and annuities,
§23-81-109.

Property and casualty insurance,
§23-80-303.

Simplification of insurance policies,
§23-80-203.

Viatical settlements, §23-81-602.

Policy form.

Insurance policies.

Property and casualty insurance,
§23-80-303.

Medicare supplement insurance
minimum standards, §23-79-403.

Simplification of life and health
insurance policy language,
§23-80-203.

Policyholder.

Life insurance policies and annuities,
§23-81-109.

Policy loan.

Life insurance policies and annuities,
§23-81-109.

DEFINED TERMS —Cont'd**Preexisting condition exclusion.**

Health insurance portability and
accountability, §23-86-303.

Premium rates applicable to individually underwritten standard risks.

Health insurance, group, conversion
policies, §23-86-115.

Premiums.

Fraternal benefit societies, §23-74-104.
Insurance policies, §23-79-101.

Provider.

Comprehensive health insurance pool,
§23-79-503.

Health maintenance organizations,
§23-76-102.

Tax credits for medically necessary
foods, §23-79-701.

Published monthly average.

Life insurance policies and annuities,
§23-81-109.

Purchaser.

Health insurance, small employer
health insurance purchasing
groups, §23-86-502.

Qualified high risk pool.

Comprehensive health insurance pool,
§23-79-503.

Radiation treatment.

Health insurance, outpatient coverage,
§23-85-133.

Rating period.

Small employer health insurance,
§23-86-202.

Recklessly.

Viatical settlements, §23-81-602.

Regulation.

Health insurance portability and
accountability, §23-86-303.

Renal dialysis.

Health insurance, outpatient coverage,
§23-85-133.

Resident eligible person.

Comprehensive health insurance pool,
§23-79-503.

Rules.

Fraternal benefit societies, §23-74-104.

Screening mammography.

Insurance policies, §23-79-140.

Small employer.

Health insurance, §23-86-202.

Health insurance portability and
accountability, §23-86-303.

Small employer carrier.

Health insurance, §23-86-202.

Small-group markets.

Health insurance portability and
accountability, §23-86-303.

DEFINED TERMS —Cont'd**Society.**

Fraternal benefit societies, §23-74-104.

Special purpose entity.

Viatical settlements, §23-81-602.

State.

Health insurance portability and accountability, §23-86-303.

State law.

Health insurance portability and accountability, §23-86-303.

State-mandated health benefits.

Health insurance consumer choice, §23-79-802.

Health insurance, small employer health insurance purchasing groups, §23-86-502.

Stop loss coverage.

Comprehensive health insurance pool, §23-79-503.

Terminally ill.

Viatical settlements, §23-81-602.

Text.

Insurance policies.

Simplification, §23-80-206.

Theft service.

Automobile clubs or associations, §23-77-101.

Total eligible employees.

Health insurance, small employer health insurance purchasing groups, §23-86-502.

Touring service.

Automobile clubs or associations, §23-77-101.

Towing service.

Automobile clubs or associations, §23-77-101.

Trade adjustment assistance eligible person.

Comprehensive health insurance pool, §23-79-503.

Viatical settlement broker,

§23-81-602.

Viatical settlement contract,

§23-81-602.

Viatical settlement provider,

§23-81-602.

Viatical settlement purchaser,

§23-81-602.

Viaticated policy, §23-81-602.**Viator, §23-81-602.****Waiting period.**

Health insurance portability and accountability, §23-86-303.

DEFINED TERMS —Cont'd**X rays.**

Health insurance, outpatient coverage, §23-85-133.

DEPOSITS.**Hospital and medical service corporations.**

Protection of subscribers, §23-75-109.

Required, §23-75-109.

DIABETES.

Insurance coverage, §§23-79-601 to 23-79-607.

Applicability.

Exceptions, §23-79-607.

Policies, §23-79-606.

Definitions, §23-79-601.

Exclusions, §23-79-604.

Requirements, §23-79-603.

Rules and regulations, §23-79-605.

Self-management training, §23-79-602.

DIRECT ACTION.

Insurers, §23-79-210.

DISABILITY INSURANCE.

Credit life and disability insurance, §§23-87-101 to 23-87-119.

See CREDIT LIFE AND DISABILITY INSURANCE.

DISABLED PERSONS.**Insurance.**

Health insurance.

Policies.

Age requirement, §23-85-131.

Exceptions to requirements, §23-85-131.

DISCRIMINATION.**Health insurance portability and accountability.**

Discrimination based on health status, §23-86-306.

DIVORCE.**Insurance.**

Group and blanket health insurance.

Continuation of coverage upon change in marital status, §23-86-114.

DRUG ABUSE.**Insurance.**

Care and treatment of alcohol and drug dependency.

Insurers transacting health, accident or disability insurance in state.

Requirements of group policies, contracts and plans providing hospital and medical coverage, §23-79-139.

DRUNKENNESS.**Insurance.**

Care and treatment of alcohol and drug dependency.

Insurers transacting health, accident or disability insurance in state.

Requirements of group policies, contracts and plans providing hospital and medical coverage, §23-79-139.

E**EDUCATION.****Insurance.**

School districts.

Direct actions against insurers, §23-79-210.

EVIDENCE.**Health maintenance organizations.**

Coverage and charges for health care services, §23-76-112.

Insurance.

Policies.

Applications, §23-79-106.

EXAMINATIONS.**Health maintenance organizations.**

Taking when commissioner deems necessary, §23-76-122.

Hospital and medical service corporations.

Annual report and examination, §23-75-114.

EXECUTIONS.**Fraternal benefit societies.**

Benefits not liable to attachment, garnishment or other process, §23-74-403.

F**FEES.****Automobile clubs or associations.**

Agents.

Licenses.

Annual license fee, §23-77-108.

Certificates of authority, §23-77-106.

Fraternal benefit societies.

Licenses, §23-74-603.

Health maintenance organizations.

Payment of fees to commissioner, §23-76-127.

Hospital and medical service corporations.

Certificates of authority, §23-75-107.

FIDUCIARIES.**Health maintenance organizations.**

Responsibilities of directors and officers, §23-76-111.

FINES.**Automobile clubs or associations.**

Failure to comply with provisions, §23-77-103.

Burial associations.

Failure to comply with provisions, §23-78-104.

False claim, promise or representation of agent, §23-78-114.

False entries in books, §23-78-118.

False statements, §23-78-111.

Fraternal benefit societies.

Fraudulent statements or solicitations of membership, §23-74-703.

Fraud.

Burial association representatives, §23-78-114.

Health maintenance organizations.

Insolvency protection.

Hold harmless violations, §23-76-118.

Willful violations of chapter, §23-76-105.

Insurance.

Prescription drug benefits, §23-79-149.

FOOD.**Medically necessary food or low protein modified food products.**

Children with phenylketonuria.

Definitions, §23-79-701.

Health insurance coverage, §23-79-703.

Income tax credit for individual or family of child, §23-79-702.

FORMS.**Insurance.**

See INSURANCE.

FRATERNAL BENEFIT SOCIETIES,

§§23-74-101 to 23-74-705.

Actions.

Indemnification or reimbursement of persons threatened by, §23-74-203.

Adult membership.

Minimum age, §23-74-201.

Amendments to laws, §23-74-302.

Benefit contracts.

Binding and controlling, §23-74-404.

Annuities.

Contractual benefits provided by societies, §23-74-401.

Appeals.

Decisions and findings of commissioner of insurance.

Review of, §23-74-702.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Applicability of other code provisions, §23-74-705.**Articles of incorporation.**

Bonds, surety.

Applicants for incorporation,
§23-74-301.

Contents requirements, §23-74-301.

Filing, §23-74-301.

Foreign or alien societies.

Filing prior to transacting business
in state, §23-74-605.

Organization generally, §23-74-301.

Assets.Held, invested and disbursed for use
and benefit of society, §23-74-502.**Assignments.**

Benefit contracts, §23-74-404.

Attachment.

Benefits not attachable, §23-74-403.

Attorney general.

Injunctions.

Domestic societies.

Commencing action, §23-74-606.

Recognition of proceedings.

Application or petition made by
attorney general upon request
of commissioner, §23-74-608.**Benefit contracts**, §23-74-404.

Amendments to laws.

Binding and controlling, §23-74-404.

Annuity benefits.Contractual benefits provided by
societies, §23-74-401.**Assignment.**

Terms and conditions, §23-74-404.

Attachment.

Benefits not liable to, §23-74-403.

Beneficiaries, §23-74-402.**Assets.**Prohibited from acquiring
individual rights in,
§23-74-502.

Changing beneficiaries, §23-74-402.

Designating, §23-74-402.

Cash surrender values, §23-74-405.**Certificates.**

Defined, §23-74-104.

Issuance.

Requirements, §23-74-404.

Standards for valuation, §23-74-601.

Valuation, §23-74-601.

Contractual benefits provided by
societies, §23-74-401.**Coverage.**Societies to specify persons covered
by contractual benefits,
§23-74-401.**FRATERNAL BENEFIT SOCIETIES**

—Cont'd

Benefit contracts —Cont'd**Death benefits.**Contractual benefits provided by
societies, §23-74-401.

Defined, §23-74-104.

Disability benefits.Temporary or permanent disability
benefits.Contractual benefits provided by
societies, §23-74-401.**Endowment benefits.**Contractual benefits provided by
societies, §23-74-401.**Funeral benefits.**Provision for payment of,
§23-74-402.**Garnishment.**

Benefits not liable to, §23-74-403.

Generally, §23-74-404.

Hospital, medical or nursing benefits.Contractual benefits provided by
societies, §23-74-401.**Laws.****Amendments.**Binding and controlling,
§23-74-404.**Liability.**Benefits not liable to attachment,
garnishment or other process,
§23-74-403.**Life insurers.**

Benefits authorized for life insurers.

Contractual benefits provided by
societies, §23-74-401.**Loans.**

Certificate loans, §23-74-405.

Minors.Issuance of contract prior to
attaining age of majority.

Bound by term, §23-74-404.

Monument or tombstone benefits.Contractual benefits provided by
societies, §23-74-401.**Nonforfeiture benefits**, §23-74-405.**Personal representatives.**

Payment of benefits to, §23-74-402.

Terms and conditions, §23-74-404.

Valuation of certificates.

Standards of, §23-74-601.

Benefit members.

Defined, §23-74-104.

Bonds, surety.

Articles of incorporation.

Applicants for incorporation,
§23-74-301.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Certificates of authority.

Issuance, §23-74-301.

Preliminary certificates, §23-74-301.

Children's Preventive Health Care Act.

Generally, §23-79-141.

Consolidation, §23-74-305.**Contracts.**

Consolidation or merger, §23-74-305.

Conversion into mutual life insurance companies, §23-74-306.**Death.**

Contractual benefits provided by societies.

Death benefits, §23-74-401.

Definitions, §23-74-101.

Generally, §23-74-104.

Lodge system, §23-74-102.

Representative form of government, §23-74-103.

Diabetes coverage, §§23-79-601 to 23-79-607.**Disabilities.**

Contractual benefits provided by societies.

Temporary or permanent disability benefits, §23-74-401.

Domestic societies.

Consolidation or merger, §23-74-305.

Conversion into mutual life insurance companies, §23-74-306.

Deficiencies.

Hearings, §23-74-606.

Injunctions, liquidation or receivership, §23-74-606.

Notice, §23-74-606.

Examination, §23-74-604.

Exemptions of certain societies, §23-74-704.

Hearings.

Injunctions, liquidation or receivership, §23-74-606.

Injunctions.

Grounds, §23-74-606.

Procedures, §23-74-606.

Liquidation.

Grounds, §23-74-606.

Procedure, §23-74-606.

Notice.

Deficiencies, §23-74-606.

Hearings.

Injunctions, liquidation or receivership, §23-74-606.

Organization.

Generally, §23-74-301.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Domestic societies —Cont'd

Receivership.

Grounds, §23-74-606.

Procedure, §23-74-606.

Elections.

Officers of society, §23-74-103.

Supreme governing body.

Eligibility of members to vote, §23-74-103.

Endowments.

Contractual benefits provided by societies.

Endowment benefits, §23-74-401.

Examination of societies, §23-74-604.**Executions.**

Benefits not liable to attachment, garnishment or other process, §23-74-403.

Exemptions from general insurance laws, §23-74-503.**Exemptions of certain societies, §23-74-704.****Fees.**

Licenses, §23-74-603.

Foreign or alien societies.

Admission to state, §23-74-605.

Amendments to laws.

Filing, §23-74-302.

Articles of incorporation.

Filing prior to transacting business in state, §23-74-605.

Examination, §23-74-604.

Investments, §23-74-501.

Licenses.

Notice.

Suspension, revocation or refusal, §23-74-607.

Required to transact business in state, §23-74-605.

Suspension, revocation or refusal.

Grounds, §23-74-607.

Notice, §23-74-607.

Procedure, §23-74-607.

Notice.

Licenses.

Suspension, revocation or refusal, §23-74-607.

Qualifications.

Admission to state, §23-74-605.

Fraud.

Penalties.

Fraudulent statements, §23-74-703.

Funds generally, §23-74-502.**Funerals.**

Contractual benefits.

Payment of funeral benefits, §23-74-402.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Garnishment.

Benefits not liable to garnishment,
§23-74-403.

Hearings.

Domestic societies.

Injunctions, liquidation or
receivership, §23-74-606.

Examination of societies.

Opportunity to respond before
findings made public,
§23-74-604.

**Hospital, medical or nursing
benefits.**

Contractual benefits provided by
societies, §23-74-401.

Indemnification.

Persons indemnified and reimbursed
by societies, §23-74-203.

Injunctions.

Domestic societies.

Grounds, §23-74-606.

Procedures, §23-74-606.

Recognition of proceedings.

Application or petition required to
be made by attorney general,
§23-74-608.

Institutions.

Not-for-profit institutions.

Created, maintained and operated
by, §23-74-303.

Insurance.

Directors, officers, employees or
agents.

Powers to purchase on behalf of,
§23-74-203.

General insurance laws.

Exemptions from, §23-74-503.

Life insurers.

Contractual benefits provided by
societies.

Benefits as authorized for life
insurers, §23-74-401.

Mutual life insurance companies.

Conversion into, §23-74-306.

Reinsurance, §23-74-304.

Investments.

Authorized investments, §23-74-501.

Funds, §23-74-502.

Laws.

Amendments, §23-74-302.

Benefit contracts.

Amendments.

Binding and controlling,
§23-74-404.

Defined, §23-74-104.

Waiver, §23-74-204.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Liability.

Benefits.

Attachment, garnishment or other
process.

Benefits not liable for, §23-74-403.

Supreme governing body.

Officers and members.

Not personally liable for benefits
provided, §23-74-203.

Licenses.

Agents, §23-74-609.

Exceptions to requirement,
§23-74-609.

Fees, §23-74-603.

Foreign or alien societies.

Required for transacting business in
state, §23-74-605.

Suspension, revocation or refusal.

Grounds, §23-74-607.

Notice, §23-74-607.

Procedure, §23-74-607.

Notice.

Foreign or alien societies.

Suspension, revocation or refusal,
§23-74-607.

Renewal, §23-74-603.

Suspension, revocation or refusal.

Foreign or alien societies,
§23-74-607.

Transacting business in state.

Required for, §23-74-603.

Liquidation.

Domestic societies.

Grounds, §23-74-606.

Procedure, §23-74-606.

Loans.

Benefit contracts.

Certificate loans, §23-74-405.

Lodges.

Defined, §23-74-104.

Lodge system, §23-74-102.

Children.

Organizing and operating lodges for
children, §23-74-102.

Subordinate lodges.

Meetings.

Required to hold regular meeting,
§23-74-102.

Meetings.

Supreme governing body.

Where held, §23-74-202.

Membership.

Adult membership.

Minimum age, §23-74-201.

Age.

Adult membership.

Minimum age, §23-74-201.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Membership —Cont'd

Assets.

Members prohibited from acquiring individual rights, §23-74-502.

Classes.

Eligibility standards.

Provided for in laws or rules, §23-74-201.

Consolidations or mergers.

Text furnished to, §23-74-305.

Conversion into mutual life insurance companies.

Vote required, §23-74-306.

Grievance or complaint procedures.

Providing in laws or rules for, §23-74-202.

Qualifications, §23-74-201.

Rights in society.

Personal to members and not assignable, §23-74-201.

Social members, §23-74-201.

Merger, §23-74-305.**Minors.**

Benefit contracts.

Issuance prior to attaining age of majority.

Bound by terms, §23-74-404.

Children's Preventive Health Care Act.

Generally, §23-79-141.

Lodge system.

Organizing and operating lodges for children, §23-74-102.

Mutual life insurance companies.

Conversion into, §23-74-306.

Not-for-profit institutions.

Created, maintained and operated by societies, §23-74-303.

Notice.

Consolidations and mergers, §23-74-305.

Domestic societies.

Deficiency or deficiencies, §23-74-606.

Hearings.

Injunctions, liquidation or receivership, §23-74-606.

Examination of societies.

Opportunity to respond to before findings made public, §23-74-604.

Foreign or alien societies.

Licenses.

Suspension, revocation or refusal.

Notice of deficiency, §23-74-607.

Publication.

Required notice, §23-74-202.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Offices.

Domestic societies.

Location, §23-74-202.

Organization.

Generally, §23-74-301.

Other code provisions.

Applicability of, §23-74-705.

Penalties.

Generally, §23-74-703.

Reports.

Failure to file required reports, §23-74-602.

Perjury, §23-74-703.**Personal representatives.**

Contractual benefits.

Payment of benefits to, §23-74-402.

Powers.

Generally, §23-74-105.

Premiums.

Defined, §23-74-104.

Publication.

Notices.

Required notices, §23-74-202.

Purposes, §23-74-105.**Receivers.**

Domestic societies.

Receivership of domestic societies.

Grounds, §23-74-606.

Procedure, §23-74-606.

Records.

Certificates of authority, §23-74-301.

Registered agent.

Service of process, §23-74-701.

Reinsurance, §23-74-304.**Reports.**

Required reports, §23-74-602.

Failure to file.

Penalties, §23-74-602.

Representative form of government, §23-74-103.

Liability of officers and members of supreme governing body.

Not personally liable for benefits provided, §23-74-203.

Officers of societies.

Election, §23-74-103.

Liability.

Not personally liable for benefits provided, §23-74-203.

Supreme governing body.

Consolidations and mergers.

Duties, §23-74-305.

Conversion into mutual life insurance companies.

Vote required, §23-74-306.

FRATERNAL BENEFIT SOCIETIES

—Cont'd

Representative form of government

—Cont'd

Supreme governing body —Cont'd

Election to body.

Eligibility of members to vote,
§23-74-103.

How constitutes, §23-74-103.

Liability.

Not personally liable for benefits
provided, §23-74-203.

Meetings.

Where held, §23-74-202.

Rules.

Defined, §23-74-104.

Service of process.

Registered agent, §23-74-701.

Taxation.

Exemptions from taxation, §23-74-504.

Trade practices act.

Subject to, §23-74-610.

**Unfair methods of competition and
unfair and deceptive acts and
practices, §23-74-610.****Valuation.**

Benefit contracts.

Certificates.

Standards of valuation,
§23-74-601.**Violations of chapter.**

Penalties generally, §23-74-703.

Waiver.

Laws of societies, §23-74-204.

FRAUD.**Fraternal benefit societies.**

Penalties.

Fraudulent statements, §23-74-703.

Viatical settlements.Fraud prevention and control,
§23-81-612.**FUNDS.****Health maintenance organizations.**Fiduciary responsibilities of directors
and officers, §23-76-111.**Safety-net benefit fund.**Health insurance flexibility and
accountability, §23-79-1004.**FUNERALS.****Fraternal benefit societies.**

Contractual benefits.

Payment of funeral benefits,
§23-74-402.**G****GARNISHMENT.****Fraternal benefit societies.**Benefits not liable to garnishment,
§23-74-403.**GIFTS.****Hospital and medical service
corporations.**Power to make donations for the
public welfare, §23-75-121.**GROUP AND BLANKET HEALTH
INSURANCE.**

See HEALTH INSURANCE.

**GROUP LIFE INSURANCE AND
ANNUITIES, §§23-83-101 to
23-83-126.****Assignment of rights, §23-83-125.**

Insurer.

Protection of insurer's rights,
§23-83-126.**Association groups, §23-83-106.****Authorized insurers.**

Placement, §23-83-123.

Conversion right.

Notice, §23-83-122.

Credit union groups, §23-83-105.**Debtor groups, §23-83-105.****Employee groups, §23-83-102.****Group requirements, §23-83-101.****Group types, §§23-83-102 to 23-83-106.****Incontestability provision,
§23-83-111.****Insurability provisions, §23-83-113.****Insurers.**

Assignment of rights.

Protection of insurer's rights,
§23-83-126.

Authorized insurers, §23-83-123.

Unauthorized insurers, §23-83-124.

Labor union groups, §23-83-103.**Placement with authorized insurers,
§23-83-123.****Policy.**

Age provision, §23-83-114.

Continuation of coverage during
disability, §23-83-120.Conversion on termination of
eligibility provision, §§23-83-117,
23-83-118.Copy of application attached,
§23-83-112.

Death pending conversion, §23-83-119.

Issuance of certificate to policyholder,
§23-83-116.Payment of benefits provision,
§23-83-115.Provisions, §§23-83-109 to 23-83-121.
Required provisions, §23-83-109.**Premiums.**

Grace period for payment, §23-83-110.

Restrictions on coverage.

Certain groups, §23-83-107.

GROUP LIFE INSURANCE AND ANNUITIES —Cont'd

Restrictions on coverage —Cont'd
Spouses and dependent children,
§23-83-108.

Trustee groups, §23-83-104.

Unauthorized insurers, §23-83-124.

H**HEALTH.****Insurance.**

Comprehensive health insurance pool,
§§23-79-501 to 23-79-510.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Maintenance organizations.

General provisions, §§23-76-101 to
23-76-132.

See HEALTH MAINTENANCE
ORGANIZATIONS.

HEALTH CARE PLANS.**Health maintenance organizations.**

Applicability of provisions to health
care plans, §23-76-103.

Generally, §§23-76-101 to 23-76-132.

See HEALTH MAINTENANCE
ORGANIZATIONS.

HEALTH CARE PORTABILITY AND ACCOUNTABILITY.**Comprehensive health insurance pool,** §§23-79-501 to 23-79-514.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Generally, §§23-86-301 to 23-86-314.

See HEALTH INSURANCE.

HEALTH INSURANCE.**Actions.**

Policies.

Legal actions, §23-85-116.

Adopted minors.

Coverage for adopted minors,
§23-79-137.

Alcoholic beverages.

Policy provisions, §23-85-126.

Provisions of chapter, §23-85-102.

Ambulance services.

Direct reimbursement, §23-79-148.

Beneficiaries.

Change of beneficiary, §23-85-117.

Benefits.

Portability and accountability.

Exceptions, §23-86-310.

Prohibition of reduction of benefits due
to other insurance contracts,
§23-85-132.

HEALTH INSURANCE —Cont'd**Breast cancer.**

Mammogram coverage, §23-79-140.

Cancer prescription medication coverage, §23-79-147.**Change of occupation,** §23-85-119.**Children's Preventive Health Care Act,** §23-79-141.**Claims.**

Forms, §23-85-111.

Standard claims form, §23-85-136.

Group and blanket health
insurance, §23-86-117.

Notice of claims, §23-85-110.

Payment of claims, §§23-85-113,
23-85-114.

Time of payment, §23-85-113.

Competition.

Freedom of choice among health
benefit plans, §§23-86-401 to
23-86-406.

Comprehensive health insurance pool, §§23-79-501 to 23-79-510.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Confidentiality of information.

Portability and accountability.

Disclosure of information by health
plan issuers, §23-86-313.

Consumer choice, §§23-79-801 to 23-79-805.

Citation, §23-79-801.

Definitions, §23-79-802.

Health benefits plan.

Defined, §23-79-802.

Optional plans not providing
state-mandated benefits,
§23-79-803.

Rulemaking to implement, §23-79-805.

Short title of act, §23-79-801.

State-mandated health benefits.

Defined, §23-79-802.

Optional plans not providing
state-mandated benefits,
§23-79-803.

Continuation of coverage.

Group and blanket disability
insurance, §23-86-114.

Controlled substances.

Policy provisions, §23-85-126.

Counselors.

Group and blanket health insurance.

Mental health coverage, §23-86-113.

Cranio-mandibular disorder.

Optional coverage to be offered,
§23-79-150.

HEALTH INSURANCE —Cont'd

Credit life and disability insurance, §§23-87-101 to 23-87-119.

See CREDIT LIFE AND DISABILITY INSURANCE.

Defenses.

Policies.

Time limit on certain defenses, §23-85-107.

Definitions.

Outpatient services, §23-85-133.

Denial of benefits.

Other insurance, §23-85-132.

Group and blanket insurance, §23-86-111.

Diabetes coverage, §§23-79-601 to 23-79-607.

Earnings.

Relation of earnings to insurance, §23-85-122.

Entitlement notwithstanding policy provisions.

Health services performed by professionals not licensed under Arkansas medical practices act, §23-79-114.

Services performed by outpatient centers, §23-79-115.

Flexibility and accountability initiative, §§23-79-1001 to 23-79-1005.

Duties of department of human services, §23-79-1005.

Legislative findings, §23-79-1001.

Medicaid demonstration initiative, §23-79-1002.

Safety-net benefit fund, §23-79-1004.

Safety-net benefit program, §23-79-1003.

Forms.

Claims, §23-85-111.

Policies, §23-85-104.

Franchise disability insurance law, §23-85-101.

Freedom of choice among health benefit plans, §§23-86-401 to 23-86-406.

Citation of provisions, §23-86-401.

Definitions, §23-86-403.

Legislative findings and intent, §23-86-402.

Optional health benefit plans, §23-86-404.

Pricing according to actuarial principles, §23-86-405.

Short title, §23-86-401.

Specific coverages not required by provisions, §23-86-406.

HEALTH INSURANCE —Cont'd

General provisions, §§23-85-101 to 23-85-139.

Grace period, §23-85-108.

Group and blanket health insurance, §§23-86-101 to 23-86-120.

Administration of benefits, §23-86-110.

Adopted minors.

Coverage for adopted minors, §23-79-137.

Applications.

Not required, §23-86-103.

Authorized insurers.

Placement of insurance exclusively with authorized insurers, §23-86-107.

Certificates.

Not required, §23-86-103.

Policies.

Application and certificates not required, §23-86-103.

Continuation of coverage, §23-86-114.

Optional continuation of benefit provisions, §23-86-109.

Persons hospitalized on date of termination of policy or contract, §23-86-116.

Conversion policy, §23-86-115.

Offer at termination of continued coverage, §23-86-114.

Counselors.

Mental health coverage for, §23-86-113.

Definitions.

Blanket accident and health insurance, §23-86-101.

Group accident and health insurance, §23-86-106.

Denial of benefits.

Other insurance, §23-86-111.

Direct payment of hospital or medical services, §23-86-112.

Disclosures to policyholders.

Employees under comprehensive health insurance policy, §23-86-119.

Forms.

Standard disability insurance claim form, §23-86-117.

Hospice care coverage for terminally ill, §23-86-120.

Impairment of speech or hearing.

Hearing devices exempt from coverage, §23-79-130.

Offer of coverage, §23-79-130.

Rejection of coverage, §23-79-130.

Time for acceptance, §23-79-130.

HEALTH INSURANCE —Cont'd **Group and blanket health insurance** —Cont'd

- Information disclosed to insured employees, §23-86-119.
- In vitro fertilization.
 - Included as covered expense.
 - Required of companies doing business in state, §23-86-118.

Medicare supplement insurance, §§23-79-401 to 23-79-410.

Mental health.

- Psychological examiner coverage, §23-79-142.

Mental illness, §23-86-113.

- Payment of benefits, §23-86-104.

Minors.

Coverage.

- Denial or restriction of coverage.
 - Certain policy provisions void, §23-79-144.

- Payment of benefits, §23-86-104.

Optional continuation of benefit provisions, §23-86-109.

Other insurance.

- Denial or reduction of benefits, §23-86-111.

Other like insurance.

- Payment of benefits where other like insurance exists, §23-86-111.

Payment of benefits, §23-86-104.

- Existence of other like insurance.
 - Effect, §23-86-111.

Policies.

Applications.

- Not required, §23-86-103.

Certificates.

- Not required, §23-86-103.

Direct payment of hospital or medical services, §23-86-112.

Provisions required, §§23-86-102, 23-86-108.

Premiums.

- Conversion policy, §23-86-115.

Provisions required, §§23-86-102, 23-86-108.

Reduction of benefits.

- Other insurance, §23-86-111.

Required provisions, §§23-86-102, 23-86-108.

Secondary carrier.

- Administration of benefits, §23-86-110.

Standard disability insurance claim form, §23-86-117.

Substance abuse coverage, §23-79-139.

HEALTH INSURANCE —Cont'd **Group and blanket health insurance** —Cont'd

Test tube babies.

In vitro fertilization.

Included as covered expense.

Required of companies doing business in state, §23-86-118.

Handicapped persons.

Policies.

- Exceptions to requirements, §23-85-131.

Hospice care coverage for terminally ill.

Offered to master group contract holder, §23-86-120.

Illegal occupations, §23-85-125.

In vitro fertilization.

Coverage required, §23-85-137.

Group and blanket health insurance.

Coverage required, §23-86-118.

Losses.

Proof, §23-85-112.

Major medical benefits coverage.

Individual health insurance coverage.

Renewal of policy, exceptions, §23-79-119.

Mammograms.

Coverage for mammogram screening of occult breast cancer.

Generally, §23-79-140.

Mandated health insurance benefits advisory commission, §§23-79-901 to 23-79-905.

Assessment of proposed mandated benefits.

Duties of commission, §23-79-903.

Composition, §23-79-902.

Contracting for services, §23-79-904.

Duties, §23-79-903.

Established, §23-79-902.

Internal operation, §23-79-902.

Legislative intent, §23-79-901.

Purpose of provisions, §23-79-901.

Reports, §23-79-905.

Staff assistance, §23-79-904.

Terms, §23-79-902.

Medically necessary foods or low protein modified food products.

Individuals or families with children with phenylketonuria, §23-79-703.

Definitions, §23-79-701.

Medicare supplement insurance, §§23-79-401 to 23-79-410.

Mental health.

Group and blanket health insurance.

Minimum benefits, §23-86-113.

Payment of benefits, §23-86-104.

HEALTH INSURANCE —Cont'd**Mental health —Cont'd****Policies.**

Exception to age limit, §23-85-131.

Psychological examiner coverage,
§23-79-142.**Minors.**Children's Preventive Health Care Act,
§23-79-141.

Denial or restriction of coverage.

Certain policy provisions void,
§23-79-144.**Newborn infants.****Policies.**Coverage for newborn infants,
§23-79-129.**Notice.**

Claims, §23-85-110.

Optional policy provisions,

§23-85-118.

Other insurance with insurer,
§23-85-121.

State statutes conformity, §23-85-124.

Other insurance.Denial or reduction of benefits,
§23-85-132.Group and blanket insurance,
§23-86-111.**Outpatient services.**

Coverage required, §23-85-133.

Definitions, §23-85-133.

Waiver of coverage, §23-85-133.

Phenylketonuria.Medically necessary food or low
protein modified food products,
§23-79-703.

Definitions, §23-79-701.

Policies.

Adopted minors.

Coverage for adopted minors,
§23-79-137.

Age limit, §23-85-131.

Mentally retarded or physically
handicapped dependents,
§23-85-131.

Misstatement of age, §23-85-120.

Applications, §23-79-105.

Autopsies, §23-85-115.

Benefits.

Prohibition or reduction of benefits
due to other insurance
contracts, §23-85-132.

Captions, §23-85-105.

Change of beneficiary, §23-85-117.

Change of occupation, §23-85-119.

Changes in provisions, §23-85-106.

Claim forms, §23-85-111.

HEALTH INSURANCE —Cont'd**Policies —Cont'd****Claims.**

Notice, §23-85-110.

Conforming to statute, §23-85-130.

Conformity with state statutes,
§23-85-124.

Conversion policies.

Group and blanket disability
insurance, §§23-86-114,
23-86-115.

Exemption of proceeds, §23-79-133.

Forms, §23-85-104.

Standard claim forms, §23-85-136.

Grace period, §23-85-108.

Group and blanket health insurance.

Applications and certifications,
§23-86-103.Conversion policies, §§23-86-114,
23-86-115.Direct payment of hospital or
medical services, §23-86-112.Required policy provisions,
§§23-86-102, 23-86-108.

Illegal occupations, §23-85-125.

Intoxicants and controlled substances,
§23-85-126.

In vitro fertilization.

Coverage required, §23-85-137.

Language simplification.

Purpose of provisions, §23-80-202.

Language simplification, §§23-80-201
to 23-80-208. See within this
heading, Policy language
simplification.

Legal actions, §23-85-116.

Medicare supplement insurance,
§§23-79-401 to 23-79-410.

Misstatement of age, §23-85-120.

Newborn infant coverage, §23-79-129.

Omissions, §23-85-105.

Optional policy provisions, §23-85-118.

Other insurance with insurer,
§23-85-121.State statutes conformity,
§23-85-124.Order of certain provisions,
§23-85-127.Other insurance in this insurer,
§23-85-121.

Payment of claims, §23-85-114.

Physical examinations, §23-85-115.

Premiums.

Refund of unearned premiums upon
death of insured, §23-85-134.

Proof of loss, §23-85-112.

Reciprocity, §23-85-129.

Reinstatement, §23-85-109.

HEALTH INSURANCE —Cont'd**Policies —Cont'd**

Relation of earnings to insurance,
§23-85-122.

Renewal.

Refusal to renew policy, §23-85-128.

Required provisions, §23-85-105.

Requirements of other jurisdictions,
§23-85-129.

Sequence of policy provisions,
§23-85-127.

Standard claim forms, §23-85-136.

Substance abuse coverage, §23-79-139.

Substitutions, §23-85-105.

Third party ownership, §23-85-103.

Time limit on certain defenses,
§23-85-107.

Time of payment of claims, §23-85-113.

Unpaid premiums, §23-85-123.

Policy language simplification,

§§23-80-201 to 23-80-208.

Applicability, §23-80-204.

Approval of forms, §23-80-208.

Authorization to use lower score,
§23-80-207.

Citation of act, §23-80-201.

Company.

Defined, §23-80-203.

Construction, §23-80-205.

Insurer.

Defined, §23-80-203.

Minimum standards, §23-80-206.

Policy or policy form.

Defined, §23-80-203.

Portability and accountability,

§§23-86-301 to 23-86-314.

Applicability, §23-86-302.

Availability of coverage.

Guaranteed for employers in group
markets, §23-86-312.

Benefits.

Exceptions, §23-86-310.

Comprehensive health insurance pool,
§§23-79-501 to 23-79-514.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Construction and interpretation,
§23-86-308.

Definitions, §23-86-303.

Disclosure of information.

Health plan insurers, §23-86-313.

Discrimination based on health status,
§23-86-306.

Effective dates, §23-86-302.

Excepted benefits, §23-86-310.

Exclusion of certain plans, §23-86-314.

HEALTH INSURANCE —Cont'd**Portability and accountability**

—Cont'd

Exclusions.

Preexisting conditions.

Limitations on exclusions,
§23-86-304.

Group health plan, §23-86-305.

Special rules, §23-86-309.

Group markets.

Guaranteed availability of coverage,
§23-86-312.

Guaranteed renewability,
§23-86-311.

Health status.

Prohibited discrimination,
§23-86-306.

Limitation of actions, §23-86-302.

Multiple employer plans.

Guaranteed renewability,
§23-86-307.

Preexisting conditions.

Limitations on exclusions,
§23-86-304.

Renewability.

Guaranteed in multiple employer
plans, §23-86-307.

Guaranteed renewability of coverage
for employers in group markets,
§23-86-311.

Rules and regulations.

Special rules for group health plans,
§23-86-309.

Title, §23-86-301.

Premiums.

Group and blanket health insurance.

Conversion policy, §23-86-115.

Method of payment.

Change, §23-85-139.

Small employer health insurance
purchasing groups, §23-86-510.

Unearned premiums.

Refund upon death of insured,
§23-85-134.

Unpaid premiums, §23-85-123.

Prescription drug benefits,

§23-79-149.

Cancer treatment medication,
§23-79-147.

Uniformity of prescription drug cards,
§§23-80-401 to 23-80-409.

See PRESCRIPTION DRUG CARD
UNIFORMITY.

Prescription drugs, §23-79-149.**Proceeds.**

Exemption of proceeds, §23-79-133.

HEALTH INSURANCE —Cont'd

Reciprocity.

Policies.

Requirements of other jurisdictions,
§23-85-129.

Reduction of benefits.

Other insurance, §23-85-132.

Group and blanket insurance,
§23-86-111.

Reinstatement of policies, §23-85-109.

Renewal.

Major medical benefits.

Individual health insurance
coverage, §23-79-119.

Refusal to renew, §23-85-128.

Reports.

Mandated health insurance benefits
advisory commission, §23-79-905.

Safety-net benefit fund.

Flexibility and accountability
initiative, §23-79-1004.

Safety-net benefit program.

Flexibility and accountability
initiative, §23-79-1003.

Scope of chapter, §23-85-102.

Small employer health insurance.

Applicability of provisions, §23-86-203.

Effective date, §23-86-209.

Commissioner.

Defined, §23-86-202.

Suspension of certain provisions.

Discretion of commissioner,
§23-86-208.

Definitions, §23-86-202.

Effective date of provisions,
§23-86-209.

Health benefit plans.

Defined, §23-86-202.

Plans to which provisions apply,
§23-86-203.

Legislative declaration.

Purpose of provisions, §23-86-201.

Premiums.

Base premium rate.

Defined, §23-86-202.

Index rate.

Defined, §23-86-202.

New business premium rate.

Defined, §23-86-202.

Rating period.

Defined, §23-86-202.

Restrictions as to rates, §23-86-204.

Suspension of certain provisions.

Discretion of commissioner,
§23-86-208.

Purpose of provisions, §23-86-201.

Records.

Maintenance by small employer
carriers, §23-86-207.

HEALTH INSURANCE —Cont'd

Small employer health insurance

purchasing groups, §23-86-501 to
23-86-512.

Administrative services.

Providing to members, §23-86-506.

Benefits requirements, §23-86-504.

Board of directors.

Organization of group, §23-86-503.

Citation of act, §23-86-501.

Composition of groups, §23-86-503.

Conflicts of interest, §23-86-508.

Cooperation among groups,
§23-86-509.

Coverage requirements, §23-86-504.

Definitions, §23-86-502.

Eligibility, §23-86-503.

Enrollments, §23-86-503.

Filing of forms, §23-86-507.

Forms.

Filing of forms, §23-86-507.

Health insurance purchasing group
health carrier.

Defined, §23-86-502.

Market service, §23-86-512.

Nonprofit organization, §23-86-503.

Notice.

State-mandated health benefits
plans.

Rejection, §23-86-505.

Pooling operations among groups,
§23-86-509.

Premiums, §23-86-510.

Reports.

Administrative services to members,
§23-86-506.

Rulemaking to implement provisions,
§23-86-511.

Size requirements, §23-86-503.

State-mandated health benefits
plans.

Defined, §23-86-502.

Rejection, §23-86-505.

Title of act, §23-86-501.

Subrogation recovery, §23-79-146.

Substance abuse coverage, **§23-79-139.**

Temporomandibular joint disorder.

Optional coverage to be offered,
§23-79-150.

Test tube babies.

Group and blanket health insurance.

Coverage required, §23-86-118.

In vitro fertilization.

Coverage required, §23-85-137.

HEALTH INSURANCE —Cont'd**Third parties.**

Ownership of policies, §23-85-103.

Unauthorized insurers.

Group and blanket health insurance.

Placement of insurance with
unauthorized insurers
prohibited, §23-86-107.

**HEALTH MAINTENANCE
ORGANIZATIONS.****Administrative law.**

Proceedings, §23-76-126.

Advertising.

Untrue or misleading advertising.

Prohibited practices, §23-76-119.

Agents.

Regulation, §23-76-120.

Annual reports, §23-76-113.**Applicability of provisions,
§23-76-103.****Bonds, surety.**

Directors, officers or partners,
§23-76-111.

Cancellation.

Prohibited practices, §23-76-119.

Cancer.

Mammogram screening of occult
breast cancer.

Coverage generally, §23-79-140.

Certificates of authority.

Applications, §23-76-107.

Fees, §23-76-127.

Issuance, §23-76-108.

Revocation, §23-76-123.

Suspension, §23-76-123.

Violations.

Penalties and enforcement,
§23-76-105.

Changes in operation.

Information provided to enrollees,
§23-76-114.

**Children's Preventive Health Care
Act.**

Generally, §23-79-141.

Claims.

Complaint system, §23-76-116.

Commissioner of insurance.

Definition of commissioner,
§23-76-102.

Competition.

Freedom of choice among health
benefit plans, §§23-86-401 to
23-86-406.

Complaint system.

Establishment, §23-76-116.

HEALTH MAINTENANCE**ORGANIZATIONS —Cont'd****Complaint system —Cont'd**

Maintenance, §23-76-116.

**Comprehensive health insurance
pool.**

General provisions, §§23-79-501 to
23-79-510.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Included in definition of insurer,
§23-79-503.

Confidentiality of information.

Filings and reports as public
documents, §23-76-128.

Medical information, §23-76-129.

Conservation.

Nature of conservation, §23-76-124.

Construction and interpretation.

Relationship to other laws, §23-76-104.

Consumer choice in health

**insurance, §§23-79-801 to
23-79-805.**

Continuation of benefits.

Protection against insolvency,
§23-76-118.

Contracts.

Authority to contract.

Director of the department of health,
§23-76-130.

Hold harmless clauses.

Protection against insolvency,
§23-76-118.

Providers.

Powers as to contracting with,
§23-76-109.

Copayments.

Tax on, §23-76-131.

Craniomandibular disorder.

Optional coverage to be offered,
§23-79-150.

Definitions, §23-76-102.**Diabetes coverage, §§23-79-601 to
23-79-607.****Duties.**

Generally, §23-76-109.

**Emergency and special out-of-area
services, indemnity benefits
covering, §23-76-109.****Enrollees.**

Information to enrollees, §23-76-114.

Open enrollment, §23-76-115.

Establishment.

Application, §23-76-107.

Guidelines, §23-76-107.

Evidence.

Coverage and charges for health care
services, §23-76-112.

HEALTH MAINTENANCE ORGANIZATIONS —Cont'd

Examinations.

Taking when commissioner deems necessary, §23-76-122.

Exemption from application of law, §23-76-104.

Fees.

Payment of fees to commissioner,
§23-76-127.

Fidelity insurance or bond for directors, officers or partners, §23-76-111.

Fiduciaries.

Responsibilities of directors and officers, §23-76-111.

Financial report, §23-76-113.

Fines.

Insolvency protection.
Hold harmless violations,
§23-76-118.

Freedom of choice among health benefit plans, §§23-86-401 to 23-86-406.

Citation of provisions, §23-86-401.

Definitions, §23-86-403.

Legislative findings and intent,
§23-86-402.

Optional health benefit plans,
§23-86-404.

Pricing according to actuarial principles, §23-86-405.

Short title, §23-86-401.

Specific coverages not required by provisions, §23-86-406.

Funds.

Fiduciary responsibilities of directors and officers, §23-76-111.

Governing body.

Members, §23-76-110.

Health insurance.

Consumer choice in health insurance,
§§23-79-801 to 23-79-805.

Hearings.

Administrative proceedings,
§23-76-126.

Hold harmless protection.

Insolvency protection, §23-76-118.

Prohibited practices as to, §23-76-119.

Hospital and medical service corporations.

Powers, §23-76-121.

Hospitals or medical facilities, constructing and operating, §23-76-109.

Indemnity benefits, offering, §23-76-109.

Information to enrollees, §23-76-114.

HEALTH MAINTENANCE ORGANIZATIONS —Cont'd

Insolvency.

Protection against insolvency,
§23-76-118.

Insurance code provisions expressly applicable, §23-76-104.

Investments.

Guidelines, §23-76-117.

Issuance of certificate of authority, §23-76-108.

Legislative findings, §23-76-101.

Licenses.

Requirement, §23-76-106.

Liquidation.

Nature of liquidation, §23-76-124.

Loans to medical groups, power to make, §23-76-109.

Mammograms.

Coverage for mammogram screening of occult breast cancer.

Generally, §23-79-140.

Material changes in operation.

Information provided to enrollees,
§23-76-114.

Medical information.

Confidentiality, §23-76-129.

Minors.

Children's Preventive Health Care Act,
§23-79-141.

Nonrenewal.

Prohibited practices, §23-76-119.

Notice.

Rules and regulations.

Promulgation, §23-76-125.

Open enrollment, §23-76-115.

Penalties.

Violations, §23-76-105.

Point-of-service basis, indemnity benefits, §23-76-109.

Powers.

Generally, §23-76-109.

Insurers and hospital and medical service corporations, §23-76-121.

Premiums.

Tax on premiums, §23-76-131.

Prescription drug benefits, §23-79-149.

Uniformity of prescription drug cards,
§§23-80-401 to 23-80-409.

See PRESCRIPTION DRUG CARD
UNIFORMITY.

Primary care physician required.

Postsecondary students.

Options for students, §23-76-132.

Prohibited practices, §23-76-119.

HEALTH MAINTENANCE**ORGANIZATIONS —Cont'd****Providers.****Lists.**

Information provided to enrollees,
§23-76-114.

Purpose, §23-76-101.

Quarterly financial reports,
§23-76-113.

Rates and charges.

Evidence of coverage and charges for
health care services, §23-76-112.

Regulation of agents, §23-76-120.

Rehabilitation.

Nature of rehabilitation, §23-76-124.

Relationship to other laws,
§23-76-104.

Reports.

Annual report, §23-76-113.

Filings and reports as public
documents, §23-76-128.

Information to enrollees, §23-76-114.

Medical information.

Confidentiality, §23-76-129.

Quarterly reports, §23-76-113.

Rules and regulations.

Promulgation by commissioner,
§§23-76-109, 23-76-125.

Scope of provisions, §23-76-103.

Security deposits.

Protection against insolvency,
§23-76-118.

Solvency.

Protection against insolvency,
§23-76-118.

Stock and stockholders.

Investments, §23-76-117.

Subrogation recovery, §23-79-146.

Substance abuse coverage,
§23-79-139.

**Suspension or revocation of
certificate of authority,**
§23-76-123.

Taxation.

Premiums and copayments.

Tax on, §23-76-131.

Temporomandibular joint disorder.

Optional coverage to be offered,
§23-79-150.

Violations.

Certificates of authority.

Penalties and enforcement,
§23-76-105.

HEARINGS.**Automobile clubs or associations.**

Insurance commissioner may conduct
hearings, §23-77-105.

HEARINGS —Cont'd**Automobile clubs or associations****—Cont'd**

Suspension or revocation of certificate,
§23-77-107.

Fraternal benefit societies.

Domestic societies.

Injunctions, liquidation or
receivership, §23-74-606.

Examination of societies.

Opportunity to respond before
findings made public,
§23-74-604.

Health maintenance organizations.

Administrative proceedings,
§23-76-126.

Insurance.

Burial associations, §§23-78-108,
23-78-124.

Policies.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

**HOSPICE CARE INSURANCE
COVERAGE.****Group and blanket health
insurance.**

Coverage, §23-86-120.

**HOSPITAL AND MEDICAL SERVICE
CORPORATIONS.**

Annual report and examination,
§23-75-114.

Appeals.

Review of decisions, §23-75-118.

Applicability of provisions,
§23-75-103.

Limited application, §23-75-104.

Miscellaneous provisions, §23-75-102.

Cancer.

Mammogram screening of occult
breast cancer.

Coverage generally, §23-79-140.

Certificates of authority.

Application, §23-75-107.

Contents, §23-75-107.

Fees, §23-75-107.

Requirements, §23-75-108.

Charities.

Donations.

Power to make donations for the
public welfare, §23-75-121.

**Children's Preventive Health Care
Act.**

Generally, §23-79-141.

**Consumer choice in health
insurance,** §§23-79-801 to
23-79-805.

HOSPITAL AND MEDICAL SERVICE CORPORATIONS —Cont'd

Contracts.

Subscription contracts, §23-75-111.

Conversion to legal reserve mutual life insurer, §23-75-122.

Approval of conversion plan,
§23-75-122.

Time for completion of conversion,
§23-75-122.

Craniomandibular disorder.

Optional coverage to be offered,
§23-79-150.

Deposits.

Protection of subscribers, §23-75-109.
Required, §23-75-109.

Diabetes coverage, §§23-79-601 to 23-79-607.

Directors.

Qualifications, §23-75-112.

Donations.

Power to make donations for the
public welfare, §23-75-121.

Entitlement notwithstanding policy provisions.

Health services performed by
professionals not licensed under
Arkansas medical practices act,
§23-79-114.

Services performed by outpatient
centers, §23-79-115.

Examinations.

Annual report and examination,
§23-75-114.

Exclusive nature of provisions, §23-75-103.

Expenses, §23-75-113.

Fees.

Certificates of authority, §23-75-107.

Health insurance.

Consumer choice in health insurance,
§§23-79-801 to 23-79-805.

Incorporation.

Requirements, §23-75-106.

Insurance.

Conversion to legal reserve mutual life
insurer, §23-75-122.

Approval of conversion plan,
§23-75-122.

Time for completion of conversion,
§23-75-122.

Investments, §23-75-113.

Judicial review of decisions, §23-75-118.

Liability.

Nonliability of corporation, §23-75-116.

Limited application of chapter, §23-75-104.

HOSPITAL AND MEDICAL SERVICE CORPORATIONS —Cont'd

Mammograms.

Coverage for mammogram screening of
occult breast cancer.

Generally, §23-79-140.

Mental health.

Psychological examiner coverage,
§23-79-142.

Minors.

Children's Preventive Health Care Act.
Generally, §23-79-141.

Nonliability of corporation, §23-75-116.

Outpatient centers.

Services performed by.
Entitlement notwithstanding policy
provisions, §23-79-115.

Participating hospitals and physicians, §23-75-110.

Physicians and surgeons.

Participating hospitals and physicians,
§23-75-110.

Professionals not licensed under
Arkansas medical practices act.

Health services performed by.

Entitlement notwithstanding
policy provisions, §23-79-114.

Relationship of physician and patient,
§23-75-105.

Policies.

Subscription contracts, §23-75-111.

Prescription drug benefits, §23-79-149.

Provisions exclusive, §23-75-103.

Quarterly reports, §23-75-114.

Relationship of physician and patient, §23-75-105.

Reports.

Annual reports, §23-75-114.

Quarterly reports, §23-75-114.

Review of decisions, §23-75-118.

Service corporations.

Defined, §23-75-101.

Subrogation recovery, §23-79-146.

Subscription contracts, §23-75-111.

Substance abuse coverage, §23-79-139.

Surpluses.

Use, §23-75-115.

Taxation.

Exemptions, §23-75-120.

Premium tax, §23-75-119.

Temporomandibular joint disorder.

Optional coverage to be offered,
§23-79-150.

HOSPITALS.**Taxation.**

- Exemption from taxation.
- Hospital and medical service corporations, §23-75-120.

HUSBAND AND WIFE.**Insurance.**

- Group and blanket health insurance.
- Continuation of coverage upon change in marital status, §23-86-114.
- Policies.
- Married woman's right to insure husband's life, §23-79-128.

I**IMMUNITY.****Comprehensive health insurance pool.**

- Board not liable for obligations of pool, §23-79-504.
- Collective actions, §23-79-512.

Fraternal benefit societies.

- Benefits.
- Attachment, garnishment or other process.
- Benefits not liable for, §23-74-403.

Supreme governing body.**Officers and members.**

- Not personally liable for benefits provided, §23-74-203.

Hospital and medical service corporations.

- Nonliability of corporation, §23-75-116.

Insurance.

- Direct actions, §23-79-210.

Viatical settlements.

- Examiners, §23-81-607.
- Fraud prevention and control, §23-81-612.

INCOME TAX.**Credits.**

- Medically necessary foods or protein modified food products.
- Individuals or families with children with phenylketonuria, §23-79-702.
- Definitions, §23-79-701.

Medically necessary foods or protein modified food products.**Tax credit.**

- Individuals or families with children with phenylketonuria, §23-79-702.
- Definitions, §23-79-701.

INDEMNIFICATION.**Fraternal benefit societies.**

- Persons indemnified and reimbursed by societies, §23-74-203.

INDUSTRIAL LIFE INSURANCE,

- §§23-82-101 to 23-82-118.

See **LIFE INSURANCE.**

INJUNCTIONS.**Fraternal benefit societies.**

- Domestic societies.
- Grounds, §23-74-606.
- Procedures, §23-74-606.
- Recognition of proceedings.
- Application or petition required to be made by attorney general, §23-74-608.

Viatical settlements.

- Civil remedies, §23-81-613.

INSURANCE.**Accident insurance.**

- Credit life and disability insurance, §§23-87-101 to 23-87-119.
- See **CREDIT LIFE AND DISABILITY INSURANCE.**

Actions.

- Direct actions, §23-79-210.
- Health insurance.
- Legal actions, §23-85-116.
- Policies.

Attorney's fees.

- Allowance of fees in suits to terminate, modify or reinstate policy, §23-79-209.

Suits against insurers, §23-79-209.**Limitation of actions, §23-79-202.****Suits against insurers, §23-79-202.****Automobile liability insurers.**

- Power to sue certain insurers, §23-79-201.

Damages and attorney's fees on loss claims, §23-79-208.**Disclosure upon request of person injured or damaged, §23-79-210.****Evidence of death of person in military service, §23-79-206.****Liability insurer may be sued direct where insured not subject to suit for tort, §23-79-210.****Part of policy, §23-79-210.****Purpose of law, §23-79-210.****Service of process, §23-79-205.****Substantial compliance as to fire insurance of personal property, §23-79-207.**

INSURANCE —Cont'd**Actions —Cont'd****Policies —Cont'd**

Suits against insurers —Cont'd

Trial by jury, §23-79-203.

Venue, §23-79-204.

Adoption.

Health insurance.

Coverage for adopted minors,
§23-79-137.**Agents.**

Burial associations.

Agent license, §23-78-113.

Policies.Information about agent to be
included in policy, §23-79-138.**Alcoholic beverages.**Care and treatment of alcohol and
drug dependency.Insurers transacting health,
accident or disability insurance
in state.Requirements of group policies,
contracts and plans providing
hospital and medical
coverage, §23-79-139.

Health insurance.

Policy provisions, §23-85-126.

Ambulances.Direct reimbursement for ambulance
services, §23-79-148.**Annuities.**

Dividends, §23-81-126.

Grace period, §23-81-122.

Individual deferred annuities.Nonforfeiture law, §§23-81-301 to
23-81-312. See within this
subheading, Nonforfeiture law
for individual deferred
annuities.**Nonforfeiture law for individual
deferred annuities.**

Additional benefits, §23-81-311.

Applicability of law, §23-81-302.

Effective date, §23-81-312.

Calculation of cash surrender
values, §§23-81-306, 23-81-308.Calculation of minimum values,
§23-81-304.Calculation of paid-up annuity
benefits, §§23-81-307, 23-81-308.Calculation of present value,
§23-81-305.**Cash surrender values.**

Calculation, §23-81-306.

Maturity date, §23-81-308.

Citation of law.

Short title, §23-81-301.

INSURANCE —Cont'd**Annuities —Cont'd****Nonforfeiture law for individual
deferred annuities —Cont'd**
Contracts.Disclosure of limited death
benefits, §23-81-309.

Required provisions, §23-81-303.

Death benefits.

Limited death benefits.

Disclosure, §23-81-309.

Effective date, §23-81-312.

Exceptions to provisions, §23-81-302.

Inclusion of lapse of time
considerations, §23-81-310.**Lapse of time considerations.**

Inclusion, §23-81-310.

Limited death benefits.

Disclosure, §23-81-309.

Maturity date, §23-81-308.

Minimum values, §23-81-304.

Calculation, §23-81-304.

Paid-up annuity benefits.

Calculation, §23-81-307.

Maturity date, §23-81-308.

Present value.

Computation, §23-81-305.

Proration of values, §23-81-311.

Required provisions, §23-81-303.

Short title of law, §23-81-301.

Title of law.

Short title, §23-81-301.

Policies.

Assignability of rights, §23-79-122.

Contestability, §23-81-123.

Dividends, §23-81-126.

Entire contract provisions,
§23-81-124.

Exemption of proceeds, §23-79-134.

Grace period, §23-81-122.

Incontestability, §23-81-123.

Misstatement of age, §23-81-125.

Reinstatement, §23-81-127.

Standard provisions, §23-81-128.

Annuity and pure endowment
contracts, §23-81-121.Reversionary annuities,
§23-81-128.**Proceeds.**

Exemptions, §23-79-134.

Reinstatement, §23-81-127.

Standard provisions, §§23-81-121,
23-81-128.Annuity and pure endowment
contracts, §23-81-121.

Reversionary annuities, §23-81-128.

INSURANCE —Cont'd**Annuities —Cont'd**

Valuation laws for life insurance and annuities, §§23-84-101 to 23-84-113.

See LIFE INSURANCE.

Annulment of marriage.

Group and blanket health insurance.
Continuation of coverage upon change in marital status, §23-86-114.

Appeals.

Burial associations.
Revocation of certificates of authority, §§23-78-124, 23-78-125.
Credit life and disability insurance.
Parties aggrieved by decisions of commissioner, §23-87-119.
Policies.
Commercial property and casualty insurance policies.
Appeals from orders of commissioner, §23-79-309.

Assessments.

Burial associations.
Membership dues and assessments, §23-78-116.

Assignments.

Group annuities and group life insurance.
Right of insured to assign any or all of his rights or incidents of ownership under policy, §23-83-125.
Assignment without prejudice, §23-83-126.

Associations.

Burial associations, §§23-78-101 to 23-78-125.
See BURIAL INSURANCE ASSOCIATIONS.

Attorneys at law.

Actions.
Suits against insurers.
Damages and attorney's fees on loss claims, §23-79-208.

Beneficiaries.

Health insurance.
Change of beneficiary, §23-85-117.
Industrial life insurance.
Policies.
Designation of beneficiary on policies, §23-82-114.

Benefits.

Children's Preventive Health Care Act, §23-79-141.

INSURANCE —Cont'd**Benefits —Cont'd**

Industrial life insurance.
Nonforfeiture benefits, §23-82-110.
Life insurance.
Fixed amounts, §23-81-402.
Payment in fixed and/or variable amounts, §23-81-402.
Variable amounts, §23-81-402.

Binders.

Policies, §23-79-120.

Bonds, surety.

Burial associations.
Board.
Executive secretary, §23-78-107.

Burial insurance associations, §§23-78-101 to 23-78-125.

See BURIAL INSURANCE ASSOCIATIONS.

Cancer.

Mammograms.
Coverage for mammogram screening of occult breast cancer.
Generally, §23-79-140.
Definitions, §23-79-112.
Prescription medication.
Coverage, §23-79-147.

Certificates.

Children's Preventive Health Care Act.
Required provisions, §23-79-141.
Credit life and disability insurance.
Forms.
Filing, approval and withdrawal of forms, §23-87-112.
Policies.
Delivery of policy or certificate, §23-87-111.
Provisions of policies and certificates.
Disclosure to debtors, §23-87-110.

Group and blanket health insurance.
Policies.

Applications and certifications, §23-86-103.

Life insurance.

Deposits.
Fees for certificate, §23-81-131.

Policies.
Commissioner's certificate on policy, §23-81-131.

Children's Preventive Health Care Act.

Benefits, §23-79-141.
Certificates.
Required provisions, §23-79-141.
Contracts.
Required provisions, §23-79-141.

INSURANCE —Cont'd**Children's Preventive Health Care Act —Cont'd****Coverage.**

Periodic physical examination,
§23-79-141.

Definitions, §23-79-141.

Health insurance, §23-79-141.

Periodic physical examinations.

Coverage for, §23-79-141.

Defined, §23-79-141.

Policies.

Required provisions, §23-79-141.

Purposes of section, §23-79-141.

Claims.

Credit life and disability insurance.

Reporting, §23-87-115.

Health insurance.

Forms, §23-85-111.

Standard claims form required,
§23-85-136.

Notice of claim, §23-85-110.

Payment of claims.

Policy provision for payment of
claims, §23-85-114.

Time of payment provision,
§23-85-113.

Life insurance.

Interest on proceeds, §23-81-118.

Payment, §23-81-113.

Premiums to accompany proceeds,
§23-81-118.

Policies.

Health, medical or surgical plan or
accident claims of \$300 or less.

Nonpayment.

Penalty for late or nonpayment
of claim, §23-79-135.

Waiver, §23-79-127.

Commercial lines property insurance.**Policies.**

Commercial property and casualty
insurance policies.

Minimum standards, §§23-79-301
to 23-79-312. See within this
heading, Policies.

Commissioner.

Property and casualty insurance policy
simplification.

Powers, §23-80-305.

Small employer health insurance.

Definition of commissioner,
§23-86-202.

Suspension of certain provisions.

Discretion of commissioner,
§23-86-208.

**INSURANCE —Cont'd
Companies.**

Direct actions against, §23-79-210.

Comprehensive health insurance pool, §§23-79-501 to 23-79-510.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Confidentiality of information.

Group and blanket health insurance.

Mental health coverage, §23-86-113.

Construction and interpretation.

Credit life and disability insurance,
§23-87-105.

Policies.

Commercial property and casualty
insurance policies.

Construed and applied in
accordance with provisions of
subchapter, §23-79-308.

Effect of subchapter upon prior
law, §23-79-304.

Controlled substances.

Health insurance.

Policy provisions, §23-85-126.

Counties.

Direct actions against insurer,
§23-79-210.

Defenses.

Health insurance.

Policies.

Time limit on certain defenses,
§23-85-107.

Definitions.

Burial associations, §23-78-101.

Children's Preventive Health Care Act,
§23-79-141.

Claims-made policy, §23-79-303.

Credit life and disability insurance,
§23-87-103.

Fraternal benefit societies, §23-74-101.

Generally, §23-74-104.

Lodge system, §23-74-102.

Representative form of government,
§23-74-103.

Group and blanket health insurance.

Blanket accident and health
insurance, §23-86-101.

Group accident and health
insurance, §23-86-106.

Health insurance.

Outpatient coverage, §23-85-133.

Health maintenance organizations,
§23-76-102.

Hospital and medical service
corporations, §23-75-101.

Industrial life insurance, §23-82-101.

Large commercial risks, §23-79-109.

INSURANCE —Cont'd**Definitions —Cont'd**

Mammograms.

Diagnostic mammography,
§23-79-140.

Screening mammography,
§23-79-140.

Policies, §23-79-101.

Life and health insurance policy
language simplification,
§23-80-203.

Premiums, §23-79-101.

Property and casualty insurance policy
simplification, §23-80-303.

Small employer health insurance,
§23-86-202.

Deposits.

Life insurance.

Capital deposits may be credited,
§23-81-135.

Certificates.

Fee for certificate, §23-81-131.

Reserves, §23-81-130.

Deficiency of deposit, §23-81-136.

Deposit of capital may be credited,
§23-81-135.

Diabetes coverage, §§23-79-601 to
23-79-607.

Direct actions statute, §23-79-210.

Disability insurance.

Credit life and disability insurance,
§§23-87-101 to 23-87-119.

See CREDIT LIFE AND

DISABILITY INSURANCE.

Disabled persons.

Health insurance policies.

Age requirement, §23-85-131.

Dividends.

Annuities, §23-81-126.

Industrial life insurance.

Policies, §23-82-109.

Life insurance.

Policy provisions, §23-81-108.

Divorce.

Group and blanket health insurance.

Continuation of coverage upon
change in marital status,
§23-86-114.

Drug abuse.

Care and treatment of alcohol and
drug dependency.

Requirements of group policies,
contracts and plans, §23-79-139.

Health insurance.

Policy provisions, §23-85-126.

INSURANCE —Cont'd**Drunkenness.**

Care and treatment of alcohol and
drug dependency.

Requirements of group policies,
contracts and plans, §23-79-139.

Education.

School districts.

Direct actions against insurers,
§23-79-210.

Employers' liability insurance.

Increase in premiums, §23-79-151.

Evidence.

Policies.

Applications, §23-79-106.

Fees.

Burial associations, §23-78-111.

Disposition of fees and charges,
§23-78-123.

Life insurance.

Certificates, §23-81-131.

Forms.

Credit life and disability insurance.

Policies.

Filing, approval and withdrawal of
forms, §23-87-112.

Health insurance.

Claims, §23-85-111.

Standard claims form required,
§23-85-136.

Policy forms, §23-85-104.

Policies.

Approval of forms, §23-79-109.

Grounds for disapproval, §23-79-110.

Noncomplying forms.

Validity, §23-79-118.

Proof of loss forms.

Furnishing, §23-79-126.

Validity of noncomplying forms,
§23-79-118.

Fraternal benefit societies.

General provisions, §§23-74-101 to
23-74-705.

See FRATERNAL BENEFIT
SOCIETIES.

Freedom of choice.

Health insurance.

Professionals not licensed under
Arkansas medical practices act.

Right to treatment by
notwithstanding policy
provisions, §23-79-114.

Handicapped persons.

Health insurance.

Policies.

Age requirement, §23-85-131.

INSURANCE —Cont'd**Health insurance.**

Comprehensive health insurance pool,
§§23-79-501 to 23-79-510.

See COMPREHENSIVE HEALTH
INSURANCE POOL.

Credit life and disability insurance,
§§23-87-101 to 23-87-119.

See CREDIT LIFE AND
DISABILITY INSURANCE.

Diabetes coverage, §§23-79-601 to
23-79-607.

Health maintenance organizations,
§§23-76-101 to 23-76-132.

See HEALTH MAINTENANCE
ORGANIZATIONS.

Health maintenance organizations.

General provisions, §§23-76-101 to
23-76-132.

See HEALTH MAINTENANCE
ORGANIZATIONS.

Hearings.

Burial associations, §§23-78-108,
23-78-124.

Policies.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

Hospitals.

Hospital and medical service
corporations, §§23-75-101 to
23-75-122.

See HOSPITAL AND MEDICAL
SERVICE CORPORATIONS.

Husband and wife.

Group and blanket health insurance.

Continuation of coverage upon
change in marital status,
§23-86-114.

Policies.

Married woman's right to insure
husband's life, §23-79-128.

Immunity.

Direct action, §23-79-210.

Industrial life insurance, §§23-82-101 to 23-82-118.

See LIFE INSURANCE.

Investments.

Burial associations.

Collections, §23-78-122.

In vitro fertilization.

Group and blanket health insurance.

Coverage required, §23-86-118.

Health insurance.

Coverage required, §23-85-137.

Large commercial risks.

Content requirements for policies in
general inapplicable, §23-79-112.

INSURANCE —Cont'd**Large commercial risks —Cont'd**

Exemption from filing and approval of
policy form requirements,
§23-79-109.

Renewal by certificate, inapplicability,
§23-79-123.

Liabilities.

Life insurance.

Limitation, §23-81-115.

Licenses.

Life insurance.

Contracts.

Variable contracts.

Licensure requirements,
§23-81-404.

Limitation of actions.

Policies.

Suits against insurers, §23-79-202.

Loans.

Life insurance.

Policy loans, §23-81-109.

Indebtedness deducted from
proceeds, §23-81-117.

Interest rate, §23-81-109.

Reinstatement provisions,
§23-81-111.

Table of installments, §23-81-110.

Local governments.

Direct actions against insurer,
§23-79-210.

Losses.

Health insurance.

Proof of loss, §23-85-112.

Major medical benefits coverage.

Individual health insurance policies.

Renewal of policy, exceptions,
§23-79-119.

Mammograms.

Coverage for mammogram screening of
occult breast cancer, §23-79-140.

Definitions, §23-79-140.

Diagnostic mammography.

Defined, §23-79-140.

Screening mammography.

Defined, §23-79-140.

Medical service corporations,

§§23-75-101 to 23-75-122.

See HOSPITAL AND MEDICAL
SERVICE CORPORATIONS.

Medical transportation services.

Direct reimbursement, §23-79-148.

Mental health.

Group and blanket health insurance.

Minimum benefits, §23-86-113.

Health insurance policies.

Age requirement, §23-85-131.

INSURANCE —Cont'd**Mental health —Cont'd**

Psychological examiner coverage,
§23-79-142.

Minors.

Adopted minors.

Health insurance.

Coverage for adopted minors,
§23-79-137.

Children's Preventive Health Care Act,
§23-79-141.

Benefits, §23-79-141.

Coverage, §23-79-141.

Definitions, §23-79-141.

Periodic physical examination.

Coverage for, §23-79-141.

Defined, §23-79-141.

Policies, contracts, certificates or
plans.

Required provisions, §23-79-141.

Coverage of newborn infants included
in all policies covering insured's
family, §23-79-129.

Effective date of coverage,
§23-79-129.

Group and blanket disability
insurance.

Coverage.

Denial or restriction of coverage.

Certain policy provisions void,
§23-79-144.

Group and blanket health insurance.

Payment of benefits, §23-86-104.

Health care coverage.

Denial or restriction of coverage.

Certain policy provisions void,
§23-79-144.

Policies.

Coverage of newborn infants
included in all policies covering
insured's family, §23-79-129.

Effective date of coverage,
§23-79-129.

Misrepresentation.

Policies.

Recovery under policy or contract,
§23-79-107.

Motor vehicles.

Extraterritorial provisions.

Liability insurance coverage.

Commercial lines, §23-79-311.

Stepdowns.

Prohibited.

Commercial lines, §23-79-312.

Municipal corporations.

Direct action against insurer,
§23-79-210.

INSURANCE —Cont'd**Newborn infants.**

Policies.

Coverage included in all policies
covering insured's family,
§23-79-129.

Certain coverage required for
approval by commissioner,
§23-79-129.

Nonforfeiture provisions.

Life insurance, §§23-81-201 to
23-81-213.

See LIFE INSURANCE.

Nonprofit corporations.

Direct actions against insurer,
§23-79-210.

Notice.

Health insurance.

Claims, notice of, §23-85-110.

Policies.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

Premiums.

Commercial property and casualty
insurance policies.

Increase of premiums, §23-79-307.

Liability policies.

Increase, §23-79-151.

Oaths.

Burial associations.

Board.

Oath of office, §23-78-105.

Fees.

Oath at payment, §23-78-111.

Penalties.

Credit life and disability insurance.

Violations, §23-87-106.

Policies.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

Policies.

Actions.

Attorney's fees.

Allowance of fees in suits to
terminate, modify or reinstate
policy, §23-79-209.

Suits against insurers, §23-79-209.

Limitation of actions, §23-79-202.

Suits against insurers, §23-79-202.

Automobile liability insurers.

Power to sue certain insurers,
§23-79-201.

Damages and attorney's fees on
loss claims, §23-79-208.

INSURANCE —Cont'd**Policies —Cont'd****Actions —Cont'd****Suits against insurers —Cont'd**

Disclosure upon request of person injured or damaged, §23-79-210.

Evidence of death of person in military service, §23-79-206.

Liability insurer may be sued direct where insured not subject to suit for tort, §23-79-210.

Part of policy, §23-79-210.

Purpose of law, §23-79-210.

Service of process, §23-79-205.

Substantial compliance as to fire insurance of personal property, §23-79-207.

Trial by jury, §23-79-203.

Venue, §23-79-204.

Agents.

Information about agents to be contained on policy, §23-79-138.

Annuities.

Assignability of rights, §23-79-134.

Contestability, §23-81-123.

Dividends, §23-81-126.

Entire contract provisions, §23-81-124.

Exemption of proceeds, §23-79-134.

Grace period, §23-81-122.

Incontestability, §23-81-123.

Misstatement of age, §23-81-125.

Reinstatement, §23-81-127.

Standard provisions, §23-81-121.

Annuity and pure endowment contracts, §23-81-121.

Reversionary annuities, §23-81-128.

Appeals.

Commercial property and casualty insurance policies.

Appeals from orders of commissioner, §23-79-309.

Applications.

Alteration, §23-79-106.

Evidence, §23-79-106.

Filing, §23-79-109.

Forms, §23-79-109.

Grounds for disapproval, §23-79-110.

Rejection.

Return of premium to rejected applicant, §23-79-108.

Representations in applications, §23-79-107.

Required, §23-79-105.

INSURANCE —Cont'd**Policies —Cont'd****Applications —Cont'd****Warranties.**

Statements in applications deemed representations and not warranties, §23-79-107.

Assignment, §23-79-124.

Binders, §23-79-120.

Bylaw provisions, §23-79-113.

Charter provisions, §23-79-113.

Children's Preventive Health Care Act. Required provisions, §23-79-141.

Claims.

Administration not waiver, §23-79-127.

Health, medical or surgical plan or accident claims of \$300 or less.

Nonpayment.

Penalty for late or nonpayment of claim, §23-79-135.

Combination policies, §23-79-117.

Commercial property and casualty insurance policies.

Minimum standards.

Administrative procedures, §23-79-309.

Appeals.

Orders of commissioner, §23-79-309.

Applicability of subchapter, §23-79-303.

Cancellation.

Extended reporting period provided at no additional charge, §23-79-306.

Certificate of authority.

Revocation or suspension for violation of subchapter, §23-79-305.

Claims-made policy.

Content requirements, §23-79-306.

Defined, §23-79-302.

Construction and interpretation.

Applied in accordance with provisions of subchapter, §23-79-308.

Effect of subchapter upon prior law, §23-79-304.

Definitions.

Claims-made policy, §23-79-302.

Exceptions to subchapter, §23-79-303.

Fire law.

Effect of subchapter upon, §23-79-304.

INSURANCE —Cont'd**Policies —Cont'd**

Commercial property and casualty insurance policies —Cont'd

Minimum standards —Cont'd Hearings.

Violations of subchapter, §23-79-305.

Intent of subchapter, §23-79-301.

Limitation of liability.

Standards policies required to meet, §23-79-307.

Notice.

Violations of subchapter, §23-79-305.

Orders.

Violations of subchapter, §23-79-305.

Penalties.

Violations of subchapter, §23-79-305.

Purposes of subchapter, §23-79-301.

Reporting period.

Extended reporting period upon cancellation or termination, §23-79-306.

Rules and regulations.

Promulgation, §23-79-310.

Standards policies required to meet, §23-79-307.

Termination.

Extended reporting period provided at no additional charge, §23-79-306.

Violations of subchapter.

Statement of alleged violations, §23-79-305.

Motor vehicle coverage.

Extraterritorial provisions, §23-79-311.

Stepdowns, §23-79-312.

Punitive damages exclusion, §23-79-307.

Renewal, §23-79-307.

Companies.

Information about companies to be contained on policy, §23-79-138.

Concealment of facts.

Recovery under policy or contract, §23-79-107.

Construction and interpretation.

Commercial property and casualty insurance policies.

Construed and applied in accordance with subchapter, §23-79-308.

INSURANCE —Cont'd**Policies —Cont'd**

Construction and interpretation —Cont'd

Commercial property and casualty insurance policies —Cont'd

Effect of subchapter upon prior law, §23-79-304.

Construction of policies, §23-79-119.

Contents.

Generally, §§23-79-111, 23-79-112.

Required provisions, §23-79-112.

Credit life and disability insurance.

Amounts of insurance authorized, §23-87-108.

Certificates.

Delivery of policy or certificate, §23-87-111.

Disclosure of provisions to debtors, §23-87-110.

Compensation.

Limitations, §23-87-117.

Delivery, §23-87-111.

Enforcement of provisions, §23-87-118.

Existing insurance.

Choice of insurer, §23-87-116.

Forms.

Filing, approval and withdrawal, §23-87-112.

Issuance, §23-87-114.

Allowable forms, §23-87-107.

Penalties for violations, §23-87-106.

Premiums.

Schedules of premium rates, §23-87-113.

Provisions required.

Disclosure to debtors, §23-87-110.

Terms of insurance, §23-87-109.

Definitions, §23-79-101.

Claims-made policy, §23-79-302.

Large commercial risks, §23-79-109.

Life and health insurance policy language simplification, §23-80-203.

Delivery of policy, §23-79-121.

Discharge.

Payment discharges insurer, §23-79-125.

Entitlement notwithstanding policy provisions.

Health services performed by professionals not licensed under Arkansas medical practices act, §23-79-114.

Services performed by outpatient centers, §23-79-115.

INSURANCE —Cont'd**Policies —Cont'd**

Execution of policies, §23-79-116.

Construction of policies, §23-79-119.

Expiration.

Renewal by certificate, §23-79-123.

Forms.

Approval, §23-79-109.

Grounds for disapproval, §23-79-110.

Noncomplying forms.

Validity, §23-79-118.

Proof of loss forms.

Furnishing, §23-79-126.

Group accident insurance.

Impairment of speech or hearing.

Hearing devices exempt from coverage, §23-79-130.

Offer of coverage, §23-79-130.

Rejection of coverage, §23-79-130.

Time for acceptance, §23-79-130.

Health insurance.

Adopted minors.

Coverage for adopted minors, §23-79-137.

Applications, §23-79-105.

Exemption of proceeds, §23-79-133.

Hearings.

Commercial property and casualty insurance policies.

Violations of subchapter, §23-79-305.

Husband and wife.

Married woman's right to insure husband's life, §23-79-128.

Industrial life insurance.

Alteration.

Authority to alter contracts, §23-82-113.

Application of provisions to term and specified insurance, §23-82-103.

Applications.

Statements in application, §23-82-106.

Beneficiaries.

Designation, §23-82-114.

Cash surrender value, §23-82-110.

Contestability, §23-82-107.

Conversion, §23-82-116.

Dividends, §23-82-109.

Grace period, §23-82-105.

Incontestability, §23-82-107.

Misstatement of age, §23-82-108.

Nonforfeiture benefits, §23-82-110.

INSURANCE —Cont'd**Policies —Cont'd**

Industrial life insurance —Cont'd Policies.

Offering, delivering or issuing for delivery.

Prohibited on or after January 1, 1988, §23-82-104.

Premiums.

Direct payment, §23-82-115.

Prohibited provisions, §23-82-118.

Reinstatement, §23-82-111.

Settlement, §23-82-112.

Title, §23-82-117.

Information to be contained, §23-79-138.

Insurable interest.

Personal insurance, §23-79-103.

Property, §23-79-104.

Large commercial risks.

Content requirements for policies in general inapplicable, §23-79-112.

Exemption from filing and approval of forms, §23-79-109.

Renewal by certificate, inapplicability, §23-79-123.

Life and health insurance policy simplification, §§23-80-201 to 23-79-208.

Applicability of provisions, §23-80-204.

Approval of forms, §23-80-208.

Company.

Defined, §23-80-203.

Construction of provisions, §23-80-205.

Insurer.

Defined, §23-80-203.

Policy.

Defined, §23-80-203.

Policy form.

Approval of forms, §23-80-208.

Defined, §23-80-203.

Readability standards, §23-80-206.

Lower scores usable, §23-80-207.

Life insurance.

Alterations.

Entire contract alterations, §23-81-106.

Applications, §23-79-105.

Certificates.

Commissioner's certificate on policy, §23-81-131.

Contestability, §23-81-105.

Dividends, §23-81-108.

Exceptions from Arkansas insurance code, §23-81-401.

INSURANCE —Cont'd**Policies —Cont'd**

Life insurance —Cont'd

Excluded or restricted coverage,
§23-81-114.

Exemption of life insurance proceeds
as to creditors, §23-79-131.

Grace period, §23-81-104.

Group life insurance.

Exemption of proceeds,
§23-79-132.

Holding of proceeds, §23-81-116.

Incontestability, §23-81-105.

After reinstatement, §23-81-129.

Loans, §23-81-109.

Indebtedness deducted from
proceeds, §23-81-117.

Interest rates, §23-81-109.

Reinstatement provisions,
§23-81-111.

Table of installments, §23-81-110.

Married woman's right to insure
husband's life, §23-79-128.

Misstatement of age, §23-81-107.

Mutilated policies, §23-81-133.

Registered policies, §23-81-130.

Registration, §23-81-132.

Reinstatement.

Incontestability after
reinstatement, §23-81-129.

Reissuance, §23-81-133.

Reserves.

Maintenance of deposit,
§23-81-134.

Restricted or excluded coverage,
§23-81-114.

Standard provisions, §23-81-103.

Surrendered policies, §23-81-133.

Title, §23-81-101.

Valuation, §23-81-132.

Variable contracts, §23-81-403.

Authority to regulate variable
contracts, §23-81-405.

Licensure requirements for
delivery of variable contracts,
§23-81-404.

Limitation of actions.

Suits against insurers, §23-79-202.

Major medical benefits coverage,
individual health insurance.

Renewal of policy, exceptions,
§23-79-119.

Medicare supplement insurance
policies, §§23-79-401 to 23-79-410.

See MEDICARE.

INSURANCE —Cont'd**Policies —Cont'd**

Minors.

Coverage of newborn infants
included in all policies covering
insured's family, §23-79-129.

Certain coverage required for
approval by commissioner,
§23-79-129.

Effective date of coverage,
§23-79-129.

Misrepresentations.

Recovery under policy or contract,
§23-79-107.

Newborn infants.

Coverage included in all policies
covering insured's family,
§23-79-129.

Certain coverage required for
approval by commissioner,
§23-79-129.

Effective date of coverage,
§23-79-129.

Noncomplying forms.

Validity, §23-79-118.

Notice.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

Right to return policy or contract,
§23-79-112.

Omissions.

Recovery under policy or contract,
§23-79-107.

Payment discharges insurer,
§23-79-125.

Penalties.

Commercial property and casualty
insurance policies.

Violations of subchapter,
§23-79-305.

Personal insurance.

Interest insurable, §23-79-103.

Premiums.

Contracts agreeing to invest
premium for benefit of insured
or certain class unlawful,
§23-79-136.

Investment.

Benefit of insured.

Violations, §23-79-136.

Negotiation, §23-79-122.

Notes, §23-79-122.

Proof of loss forms.

Furnishing, §23-79-126.

Property.

Interest insurable, §23-79-104.

INSURANCE —Cont'd**Policies —Cont'd**

Property and casualty insurance policy simplification, §§23-80-301 to 23-80-308.

See PROPERTY INSURANCE.

Renewal.

Certificates, §23-79-123.

Rules of construction, §23-79-119.

Return of policy or contract.

Statement of right in policy or contract, §23-79-112.

Riders.

Construction of policies, §23-79-119.

Rules and regulations.

Commercial property and casualty insurance policies.

Promulgation, §23-79-310.

Scope of chapter, §23-79-102.

Service of process.

Suits against insurers, §23-79-205.

Signature, §23-79-116.

Standard or uniform provisions, §23-79-111.

Standards.

Commercial property and casualty insurance policies.

Standards required to be met, §23-79-307.

Substance abuse coverage, §23-79-139.

Telephone numbers.

Information to be included, §23-79-138.

Ten day right to return policy, notice in policy, §23-79-112.

Termination, modification or reinstatement of policies.

Allowance of attorney's fees in actions, §23-79-209.

Commercial property and casualty insurance policies.

Extended reporting period, §23-79-306.

Underwriters, §23-79-117.

Venue.

Suits against insurers, §23-79-204.

Waiver.

Claims administration not waiver, §23-79-127.

Premiums.

Commercial property and casualty insurance policies.

Increase of premiums.

Notice, §23-79-307.

Credit life and disability insurance.

Schedule of premium rates, §23-87-113.

Defined, §23-79-101.

INSURANCE —Cont'd**Premiums —Cont'd**

Group and blanket health insurance.

Conversion policy, §23-86-115.

Group annuities and group life insurance.

Payment.

Grace period, §23-83-110.

Health insurance.

Method of payment.

Change, §23-85-139.

Small employer health insurance purchasing groups, §23-86-510.

Unearned premiums.

Refund upon death of insured, §23-85-134.

Unpaid premiums, §23-85-123.

Increase.

Notice required, §23-79-151.

Industrial life insurance.

Direct payment, §23-82-115.

Life insurance.

Claims.

Premiums to accompany proceeds, §23-81-118.

Construction of provisions, §23-81-118.

Interest on premiums, §23-81-118.

Payment, §23-81-112.

Policies.

Contracts agreeing to invest premium for benefit of insured or certain class unlawful, §23-79-136.

Investment.

Benefit of insured.

Violations, §23-79-136.

Negotiation, §23-79-122.

Notes, §23-79-122.

Rejection of application for insurance.

Return of premium to rejected applicant, §23-79-108.

Small employer health insurance.

Base premium rate.

Defined, §23-86-202.

Index rate.

Defined, §23-86-202.

New business premium rate.

Defined, §23-86-202.

Rating period.

Defined, §23-86-202.

Restrictions as to rates, §23-86-204.

Suspension of certain provisions.

Discretion of commissioner, §23-86-208.

Premium taxes.

Health maintenance organizations, §23-76-131.

INSURANCE —Cont'd**Prescription drug benefits,**
§23-79-149.

Uniformity of prescription drug cards,
§§23-80-401 to 23-80-409.

See PRESCRIPTION DRUG CARD
UNIFORMITY.

**Prescription medication for
treatment of cancer, §23-79-147.****Property insurance.**

Commercial property and casualty
insurance policies.

Minimum standards, §§23-79-301 to
23-79-312. See within this
heading, Policies.

Reciprocity.

Health insurance, §23-85-129.

Records.

Burial associations.

Books and records.

Maintenance, §§23-78-117,
23-78-119.

Small employer health insurance.

Maintenance of records, §23-86-207.

Reports.

Burial associations.

Semiannual reports, §23-78-120.

Credit life and disability insurance.

Claims, §23-87-115.

Reserves.

Life insurance.

Deposit of reserves, §23-81-130.

Capital deposits may be credited,
§23-81-135.

Deficiency of deposit, §23-81-136.

Maintenance of deposits,
§23-81-134.

Rules and regulations.

Burial associations, §23-78-121.

Life insurance.

Valuation law for life insurance
annuities, §23-84-113.

Policies.

Commercial property and casualty
insurance policies.

Promulgation, §23-79-310.

Service of process.

Group annuities and group life
insurance.

Unauthorized insurers, §23-83-124.

Policies.

Suits against insurers, §23-79-205.

Sickness insurance.

Credit life and disability insurance,
§§23-87-101 to 23-87-119.

See CREDIT LIFE AND
DISABILITY INSURANCE.

INSURANCE —Cont'd**Sovereign immunity.**

Direct action against insurers,
§23-79-210.

State of Arkansas.

Direct actions against insurer,
§23-79-210.

Subrogation recovery, §23-79-146.**Surviving spouse.**

Group and blanket health insurance.
Continuation of coverage upon
change in marital status,
§23-86-114.

Test tube babies.

Group and blanket health insurance.
Coverage required, §23-86-118.

Third parties.

Health insurance.

Ownership of policies, §23-85-103.

Torts.

Insured not subject to suit for tort.

Suits against insurers, §23-79-210.

Underwriters.

Policies, §23-79-117.

**Unfair competition and trade
practices.**

Fraternal benefit societies.

Unfair methods of competition and
unfair and deceptive acts and
practices, §23-74-610.

Venue.

Policies.

Suits against insurers, §23-79-204.

**Viatical settlements, §§23-81-601 to
23-81-615.**

See VIATICAL SETTLEMENTS.

Waiver.

Policies.

Claims administration not waiver,
§23-79-127.

Witnesses.

Burial associations.

Hearings, §23-78-108.

INSURANCE COMPANIES.**Health maintenance organizations.**

General provisions, §§23-76-101 to
23-76-132.

See HEALTH MAINTENANCE
ORGANIZATIONS.

Hospital and medical service

**corporations, §§23-75-101 to
23-75-122.**

See HOSPITAL AND MEDICAL
SERVICE CORPORATIONS.

Medical service corporations,

§§23-75-101 to 23-75-122.

See HOSPITAL AND MEDICAL
SERVICE CORPORATIONS.

INSURANCE COMPANIES —Cont'd Policies.

Information about company to be contained on policy, §23-79-138.

INVESTMENTS.**Fraternal benefit societies.**

Authorized investments, §23-74-501.
Funds, §23-74-502.

Health maintenance organizations.

Guidelines, §23-76-117.

Hospital and medical service corporations, §23-75-113.**Insurance.**

Burial associations.
Collections, §23-78-122.

IN VITRO FERTILIZATION.**Health insurance.**

Coverage required, §23-85-137.
Group and blanket health insurance, §23-86-118.

L**LICENSES.****Automobile clubs or associations.**

Agents, §23-77-108.

Fraternal benefit societies.

Agents, §23-74-609.
Exceptions to requirement, §23-74-609.

Fees, §23-74-603.

Foreign or alien societies.

Required for transacting business in state, §23-74-605.

Suspension, revocation or refusal.

Grounds, §23-74-607.

Notice, §23-74-607.

Notice.

Foreign or alien societies.

Suspension, revocation or refusal, §23-74-607.

Renewal, §23-74-603.

Suspension, revocation or refusal.

Foreign or alien societies, §23-74-607.

Transacting business in state.

Required for, §23-74-603.

Health maintenance organizations.

Requirement, §23-76-106.

Viatical settlements.

Requirements, §23-81-603.

Revocation or denial, §23-81-604.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.**Impaired insurers.**

Assessments, §23-87-115.

LIFE INSURANCE.

Applicability of chapter, §23-81-102.

Beneficiaries.

Unnamed beneficiaries.

Prohibited, §23-81-120.

Benefits.

Fixed amounts, §23-81-402.

Payment in fixed and/or variable amounts, §23-81-402.

Variable amounts, §23-81-402.

Certificates.

Deposits.

Fees for certificate, §23-81-131.

Policies.

Commissioner's certificate on policy, §23-81-131.

Claims.

Interest on proceeds, §23-81-118.

Payment, §23-81-113.

Premiums to accompany proceeds, §23-81-118.

Construction of provisions,

§23-81-118.

Deposits.

Capital deposits may be credited, §23-81-135.

Certificates.

Fee for certificate, §23-81-131.

Reserves, §23-81-130.

Deficiency of deposit, §23-81-136.

Deposit of capital may be credited, §23-81-135.

Dividends.

Policy provisions, §23-81-108.

Fees.

Certificates, §23-81-131.

Grace period, §23-81-104.**Group life insurance and annuities,**

§§23-83-101 to 23-83-126.

Holding of proceeds, §23-81-116.**Husband and wife.**

Married woman's right to insure husband's life, §23-79-128.

Industrial life insurance.

Applicability of chapter, §23-82-102.

Beneficiaries.

Policies.

Designation of beneficiary on policies, §23-82-114.

Benefits.

Nonforfeiture benefits, §23-82-110.

Definitions, §23-82-101.

Dividends.

Policies, §23-82-109.

Grace period, §23-82-105.

Policies.

Alteration.

Authority to alter contracts, §23-82-113.

LIFE INSURANCE —Cont'd**Industrial life insurance —Cont'd****Policies —Cont'd**

Application of provisions to term and specified insurance, §23-82-103.

Applications.

Statements in application, §23-82-106.

Beneficiaries.

Designation, §23-82-114.

Cash surrender value, §23-82-110.

Contestability, §23-82-107.

Conversion, §23-82-116.

Dividends, §23-82-109.

Grace period, §23-82-105.

Incontestability, §23-82-107.

Misstatement of age, §23-82-108.

Nonforfeiture benefits, §23-82-110.

Offering, delivering or issuing for delivery in state.

Prohibited on or after January 1, 1988, §23-82-104.

Premiums.

Direct payment, §23-82-115.

Prohibited provisions, §23-82-118.

Reinstatement, §23-82-111.

Settlement, §23-82-112.

Title, §23-82-117.

Premiums.

Direct payment, §23-82-115.

Interest.

Claims, §23-81-118.

Premiums, §23-81-118.

Liabilities.

Limitation, §23-81-115.

Licenses.**Contracts.**

Variable contracts.

Licensure requirements, §23-81-404.

Life and health insurance guaranty association.**Impaired insurers.**

Assessments, §23-87-115.

Limitation of liability, §23-81-115.**Loans.**

Policy loans, §23-81-109.

Indebtedness deducted from proceeds, §23-81-117.

Interest rate, §23-81-109.

Reinstatement provisions, §23-81-111.

Table of installments, §23-81-110.

Nonforfeiture law.

Applicability of law, §23-81-202.

Effective dates, §23-81-213.

LIFE INSURANCE —Cont'd**Nonforfeiture law —Cont'd**

Cash surrender value, §23-81-204.

Calculation in event of default, §§23-81-211, 23-81-212.

Citation of law.

Short title, §23-81-201.

Effective date, §23-81-213.

Exceptions to provisions, §23-81-202.

Paid-up benefits, §23-81-205.

Calculation, §23-81-205.

Premiums.

Calculation of adjusted premiums, §§23-81-206 to 23-81-210.

Future adjusted premiums, §23-81-210.

Industrial policies issued on or after effective date, §23-81-208.

Ordinary policies issued on or after effective date, §23-81-207.

Present values.

Calculation, §§23-81-206 to 23-81-209.

Industrial policies issued on or after effective date, §23-81-208.

Ordinary policies issued on or after effective date, §23-81-207.

Required provisions, §23-81-203.

Short title of law, §23-81-201.

Surrender of policies.

Cash surrender value, §23-81-204.

Calculation in event of default, §§23-81-211, 23-81-212.

Required provisions, §23-81-203.

Title of law.

Short title, §23-81-201.

Policies.**Alterations.**

Entire contract alterations, §23-81-106.

Applications, §23-79-105.

Certificates.

Commissioner's certificate on policy, §23-81-131.

Contestability, §23-81-105.

Dividends, §23-81-108.

Exceptions from Arkansas insurance code, §23-81-401.

Excluded or restricted coverage, §23-81-114.

Exemption of life insurance proceeds as to creditors, §23-79-131.

Grace period, §23-81-104.

LIFE INSURANCE —Cont'd**Policies —Cont'd**

Group life insurance.

Exemption of proceeds, §23-79-132.

Holding of proceeds, §23-81-116.

Incontestability, §23-81-105.

After reinstatement, §23-81-129.

Language simplification, §§23-80-201 to 23-80-208. See within this heading, Policy language simplification.

Loans, §23-81-109.

Indebtedness deducted from proceeds, §23-81-117.

Interest rates, §23-81-109.

Reinstatement provisions, §23-81-111.

Table of installments, §23-81-110.

Married woman's right to insure husband's life, §23-79-128.

Misstatement of age, §23-81-107.

Mutilated policies, §23-81-133.

Registered policies, §23-81-130.

Registration, §23-81-132.

Reinstatement.

Incontestability after reinstatement, §23-81-129.

Reissuance, §23-81-133.

Reserves.

Maintenance of deposit, §23-81-134.

Restricted or excluded coverage, §23-81-114.

Standard provisions, §23-81-103.

Surrendered policies, §23-81-133.

Title, §23-81-101.

Valuation, §23-81-132.

Variable contracts, §23-81-403.

Authority to regulate variable contracts, §23-81-405.

Licensure requirements for delivery of variable contracts, §23-81-404.

Policy language simplification,

§§23-80-201 to 23-80-208.

Applicability, §23-80-204.

Citation of act, §23-80-201.

Company.

Defined, §23-80-203.

Construction, §23-80-205.

Insurer.

Defined, §23-80-203.

Minimum standards, §23-80-206.

Approval of forms, §23-80-208.

Authorization to use lower score, §23-80-207.

Policy or policy form.

Defined, §23-80-203.

Purpose, §23-80-202.

LIFE INSURANCE —Cont'd**Premiums.**

Claims.

Premiums to accompany proceeds, §23-81-118.

Construction of provisions, §23-81-118.

Interest on premiums, §23-81-118.

Payment, §23-81-112.

Proceeds.

Exemption of life insurance proceeds as to creditors, §23-79-131.

Registered policies, §23-81-130.**Reinstatement.**

Incontestability after reinstatement, §23-81-129.

Reserves.

Deposit of reserves, §23-81-130.

Capital deposits may be credited, §23-81-135.

Deficiency of deposit, §23-81-136.

Maintenance of deposits, §23-81-134.

Scope of chapter, §23-81-102.**Unnamed beneficiaries.**

Prohibited, §23-81-120.

Valuation law for life insurance and annuities.

Actuarial opinion of reserves, §23-84-112.

Calculation of reserves, §§23-84-106 to 23-84-113.

Citation of law.

Short title, §23-84-101.

Commissioner of insurance.

Valuation of reserves by, §23-84-102.

Interest rates.

Minimum standard for valuation, §23-84-105.

Minimum standard for valuation, §§23-84-103 to 23-84-105.

Annuity contracts, §23-84-104.

Interest rates, §23-84-105.

Pure endowment contracts, §23-84-104.

Premiums.

Future premium determinations by life insurers, §23-84-113.

Reserves.

Actuarial opinion of reserves, §23-84-112.

Calculation, §§23-84-106 to 23-84-113.

Annuity contracts, §23-84-107.

Future premium determinations by life insurers, §23-84-111.

Life insurance policies and contracts, §23-84-110.

Minimum aggregate reserves for life insurance policies, §23-84-108.

LIFE INSURANCE —Cont'd**Valuation law for life insurance and annuities —Cont'd****Reserves —Cont'd****Calculation —Cont'd**

Pure endowment contracts,
§23-84-107.

Standards of valuation,
§23-84-109.

Minimum aggregate reserves for
certain life insurance policies,
§23-84-108.

Valuation by commissioner,
§23-84-102.

Rules and regulations, §23-84-113.

Standard for valuation.

Minimum standard, §§23-84-103 to
23-84-105.

Title.

Short title, §23-84-101.

Viatical settlements, §§23-81-601 to 23-81-615.

See VIATICAL SETTLEMENTS.

LIMITATION OF ACTIONS.**Health insurance portability and accountability, §23-86-302.****Insurance.****Policies.**

Suits against insurers, §23-79-202.

LIQUIDATION.**Fraternal benefit societies.****Domestic societies.**

Grounds, §23-74-606.

Procedure, §23-74-606.

LOANS.**Fraternal benefit societies.****Benefit contracts.**

Certificate loans, §23-74-405.

Insurance.

Credit life and disability insurance,
§§23-87-101 to 23-87-119.

See CREDIT LIFE AND
DISABILITY INSURANCE.

LOCAL GOVERNMENTS.**Direct actions against insurer, §23-79-210.****Insurance.**

Direct actions against insurer,
§23-79-210.

LODGES AND SOCIETIES.**Fraternal benefit societies.**

See FRATERNAL BENEFIT
SOCIETIES.

LOW PROTEIN MODIFIED FOOD PRODUCTS.**Children with phenylketonuria.**

Definitions, §23-79-701.

LOW PROTEIN MODIFIED FOOD PRODUCTS —Cont'd**Children with phenylketonuria —Cont'd**

Health insurance coverage,
§23-79-703.

Income tax credit for family of child,
§23-79-702.

M**MAJOR MEDICAL BENEFITS COVERAGE.****Individual health insurance coverage.**

Renewal of policy, exceptions,
§23-79-119.

MAMMOGRAPHY.**Diagnostic mammography.**

Defined, §23-79-140.

Screening mammography.

Defined, §23-79-140.

MARRIAGE.**Annulment.****Insurance.**

Group and blanket health insurance.
Continuation of coverage upon
change in marital status,
§23-86-114.

MEDICALLY NECESSARY FOODS.**Children with phenylketonuria.**

Definitions, §23-79-701.

Health insurance coverage,
§23-79-703.

Income tax credit for family of child,
§23-79-702.

MEDICAL RECORDS.**Health maintenance organizations.**

Confidentiality of medical information,
§23-76-129.

MEDICARE.

Defined, §23-79-403.

Supplement insurance policies,

§§23-79-401 to 23-79-410.

Administrative procedures.

Regulations adopted pursuant to act,
§23-79-409.

Advertising.

Filing requirements, §23-79-408.

Applicability, §23-79-402.

Applicants.

Defined, §23-79-403.

Certificate forms.

Defined, §23-79-403.

Certificates.

Defined, §23-79-403.

Citation of title, §23-79-401.

MEDICARE —Cont'd**Supplement insurance policies****—Cont'd**

Definitions, §23-79-403.

Format, §23-79-406.

Disclosure standards, §23-79-406.

Effective date of coverage, §23-79-404.

Examination.

Notice of free examination,

§23-79-407.

Filing requirements for advertising,

§23-79-408.

Format.

Defined, §23-79-406.

Issuers.

Defined, §23-79-403.

Loss standard ratios, §23-79-405.

Medicare.

Defined, §23-79-403.

Noncompliance with act, §23-79-410.

Notice of free examination, §23-79-407.

Penalties.

Act noncompliance, §23-79-410.

Policy forms.

Defined, §23-79-403.

Rulemaking authority, §23-79-404.

Applicability of administrative
procedures, §23-79-409.

Scope, §23-79-402.

Standards for policy provisions,

§23-79-404.

Disclosure standards, §23-79-406.

Loss ratio standards, §23-79-405.

Rulemaking authority, §23-79-404.

Title of act, §23-79-401.

MENTAL HEALTH.**Health insurance.**

Group and blanket health insurance.

Minimum benefits, §23-86-113.

Policies.

Age requirement, §23-85-131.

Psychological examiner coverage,

§23-79-142.

MERGER.**Fraternal benefit societies,**

§23-74-305.

MINORS.**Fraternal benefit societies.**

Benefit contracts.

Issuance prior to attaining age of
majority.

Bound by terms, §23-74-404.

Children's Preventive Health Care Act.

Generally, §23-79-141.

Lodge system.

Organizing and operating lodges for
children, §23-74-102.**MINORS —Cont'd****Health insurance.**

Children's Preventive Health Care Act,

§23-79-141.

Health maintenance organizations.

Children's Preventive Health Care Act,

§23-79-141.

**Hospital and medical service
corporations.**

Children's Preventive Health Care Act.

Generally, §23-79-141.

Insurance.

Children's Preventive Health Care Act,

§23-79-141.

Benefits, §23-79-141.

Coverage, §23-79-141.

Definitions, §23-79-141.

Periodic physical examination.

Coverage for, §23-79-141.

Defined, §23-79-141.

Policies, contracts, certificates or
plans.

Required provisions, §23-79-141.

Group and blanket health insurance.

Coverage.

Denial or restriction of coverage.

Certain policy provisions void,
§23-79-144.

Health care coverage.

Denial or restriction of coverage.

Certain policy provisions void,
§23-79-144.**MISDEMEANORS.****Automobile clubs or associations.**

Failure to comply with provisions,

§23-77-103.

Burial associations.

Failure to comply with provisions,

§23-78-104.

False claim, promise or representation
of agent, §23-78-114.

False entries in books, §23-78-118.

False statements, §23-78-111.

Health maintenance organizations.

Willful violations of chapter,

§23-76-105.

MISREPRESENTATION.**Insurance.**

Policies.

Recovery under policy or contract,
§23-79-107.**MOTOR VEHICLE INSURANCE.****Driver other than insured in
accident.**

Converting limits downward.

Prohibition on stepdowns.

Commercial lines, §23-79-312.

MOTOR VEHICLE INSURANCE

—Cont'd

Extraterritorial provisions.

Liability insurance coverage.

Commercial lines, §23-79-311.

Stepdowns.

Prohibited.

Commercial lines, §23-79-312.

MOTOR VEHICLES.**Associations.**

Automobile clubs or associations,

§§23-77-101 to 23-77-109.

See AUTOMOBILE CLUBS OR ASSOCIATIONS.

Clubs or associations, §§23-77-101 to 23-77-109.

See AUTOMOBILE CLUBS OR ASSOCIATIONS.

Definitions.Automobile clubs or associations,
§23-77-101.**MUNICIPAL CORPORATIONS.****Direct actions against insurer, §23-79-210.****Insurance.**Direct action against insurer,
§23-79-210.**N****NONFORFEITURE.****Life insurance.**

See LIFE INSURANCE.

NONPROFIT CORPORATIONS (1987).**Direct actions against insurer, §23-79-210.****Insurance.**Direct actions against insurer,
§23-79-210.**NOTICE.****Fraternal benefit societies.**Consolidations and mergers,
§23-74-305.

Domestic societies.

Deficiency or deficiencies,
§23-74-606.

Hearings.

Injunctions, liquidation or
receivership, §23-74-606.

Examination of societies.

Opportunity to respond to before
findings made public,
§23-74-604.

Foreign or alien societies.

Licenses.

Suspension, revocation or refusal.
Notice of deficiency, §23-74-607.**NOTICE —Cont'd****Fraternal benefit societies —Cont'd**
Publication.

Required notice, §23-74-202.

Health maintenance organizations.

Rules and regulations.

Promulgation, §23-76-125.

Medicare supplement insurance policies.Applicant's free examination,
§23-79-407.**Viatical settlements.**Fraud prevention and control,
§23-81-612.

Notice of viaticated policy, §23-81-609.

Workers' compensation.

Increase in premiums, §23-79-151.

O**OATHS.****Insurance.**

Burial associations.

Board.

Oath of office, §23-78-105.

Fees.

Oath at payment, §23-78-111.

P**PERJURY.****Fraternal benefit societies, §23-74-703.****PHARMACISTS AND PHARMACIES.****Prescription drug card uniformity, §§23-80-401 to 23-80-409.**See PRESCRIPTION DRUG CARD
UNIFORMITY.**Prescriptions.**

Insurance.

Prescription drug benefits,
§23-79-149.Prescription drug card uniformity,
§§23-80-401 to 23-80-409.See PRESCRIPTION DRUG CARD
UNIFORMITY.**PHENYLKETONURIA.****Medically necessary foods and low protein modified food products.**

Definitions, §23-79-701.

Health insurance coverage,
§23-79-703.

Income tax credit, §23-79-702.

PHYSICIANS AND SURGEONS.**Hospital and medical service corporations.**Participating hospitals and physicians,
§23-75-110.

PHYSICIANS AND SURGEONS

—Cont'd

Hospital and medical service corporations —Cont'd

- Professionals not licensed under Arkansas medical practices act.
- Health services performed by.
- Entitlement notwithstanding policy provisions, §23-79-114.
- Relationship of physician and patient, §23-75-105.

POLICIES OF INSURANCE.**Insurance generally.**

See INSURANCE.

PREMIUMS.**Insurance.**

- General provisions.
- See INSURANCE.

PRESCRIPTION DRUG CARD

UNIFORMITY, §§23-80-401 to 23-80-409.

Applicability of provisions.

- Arrangements not subject to provisions, §23-80-403.

Compliance with provisions, §23-80-407.**Contents of cards,** §23-80-404.**Definitions,** §23-80-402.**Enforcement of provisions,** §23-80-408.**Enrollment of covered persons,** §23-80-405.**Insurance commissioner enforcement of provisions,** §23-80-408.**Issuance of cards,** §23-80-405.

- No requirement that plans issue cards, §23-80-406.

Legislative intent, §23-80-401.**No requirement for plans to issue cards,** §23-80-406.**Purpose of provisions,** §23-80-401.**Requirement of uniformity,** §23-80-404.**Rulemaking to implement,** §23-80-409.**Time for compliance with provisions,** §23-80-407.**PRESCRIPTIONS.****Cancer.**

- Insurance coverage for prescription medication, §23-79-147.

Health insurance.

- Prescription medication for treatment of cancer, §23-79-147.

Insurance.

- Prescription drug benefits, §23-79-149.

PRESCRIPTIONS —Cont'd**Insurance —Cont'd**

- Prescription drug card uniformity, §§23-80-401 to 23-80-409.
- See PRESCRIPTION DRUG CARD UNIFORMITY.

Uniformity of prescription drug cards, §§23-80-401 to 23-80-409.

- See PRESCRIPTION DRUG CARD UNIFORMITY.

PRISON TERMS.**Automobile clubs or associations.**

- Failure to comply with provisions, §23-77-103.

Burial associations.

- Failure to comply with provisions, §23-78-104.
- False claim, promise or representation of agent, §23-78-114.
- False entries in books, §23-78-118.
- False statements, §23-78-111.

Fraternal benefit societies.

- Fraudulent statements and solicitations of membership, §23-74-703.

Health maintenance organizations.

- Willful violations of chapter, §23-76-105.

PROPERTY INSURANCE.**Commercial property and casualty insurance policies.**

- Minimum standards, §§23-79-301 to 23-79-312.

See CASUALTY INSURANCE.

Policy simplification.

- Applicability of provisions, §23-80-304.
- Citation of subchapter, §23-80-301.
- Commissioner.
- Powers, §23-80-305.
- Compliance with other statutorily required language, §23-80-307.
- Coverage outline, §23-80-308.
- Definitions, §23-80-303.
- Effective dates, §23-80-306.
- Implementation dates, §23-80-306.
- Legislative declaration, §23-80-302.
- Minimum standards, §23-80-306.
- Outline of coverage, §23-80-308.
- Powers of commissioner, §23-80-305.
- Purpose of subchapter, §23-80-302.
- Standards.

Minimum standards, §23-80-306.

Statutorily required language.

Compliance with, §23-80-307.

Title of subchapter, §23-80-301.

Rates and charges.

- Credit life and health insurance.
- Schedule, §23-87-113.

PUBLICATION.**Fraternal benefit societies.**

Notices.

Required notices, §23-74-202.

PUNITIVE DAMAGES.**Insurance.**

Commercial property and casualty insurance policies.

Exclusion of punitive damages, §23-79-307.

R**RATES AND CHARGES.****Health maintenance organizations.**

Evidence of coverage and charges for health care services, §23-76-112.

RECEIVERS.**Fraternal benefit societies.**

Domestic societies.

Receivership of domestic societies.

Grounds, §23-74-606.

Procedure, §23-74-606.

RECIPROCITY.**Insurance.**

Health insurance, §23-85-129.

RECORDS.**Fraternal benefit societies.**

Certificates of authority, §23-74-301.

Insurance.

Burial associations.

Books and records.

Maintenance, §§23-78-117, 23-78-119.

Small employer health insurance.

Maintenance of records, §23-86-207.

Viatical settlements.

Records retention, §23-81-607.

REPORTS.**Automobile clubs or associations.**

Annual report, §23-77-109.

Fraternal benefit societies.

Required reports, §23-74-602.

Failure to file.

Penalties, §23-74-602.

Health insurance.

Mandated health insurance benefits advisory commission, §23-79-905.

Health maintenance organizations.

Annual report, §23-76-113.

Filings and reports as public documents, §23-76-128.

Information to enrollees, §23-76-114.

Medical information.

Confidentiality, §23-76-129.

Quarterly reports, §23-76-113.

REPORTS —Cont'd**Hospital and medical service corporations.**

Annual reports, §23-75-114.

Quarterly reports, §23-75-114.

Insurance.

Burial associations.

Semiannual reports, §23-78-120.

Credit life and Health insurance.

Claims, §23-87-115.

Viatical settlements, §23-81-606.

Fraud prevention and control, §23-81-612.

S**SERVICE OF PROCESS.****Automobile clubs or associations, §23-77-106.****Fraternal benefit societies.**

Registered agent, §23-74-701.

SICKNESS INSURANCE.**Credit life and disability insurance, §§23-87-101 to 23-87-119.**

See CREDIT LIFE AND DISABILITY INSURANCE.

SMALL BUSINESSES.**Insurance.**

Small employer health insurance, §§23-86-201 to 23-86-209.

See HEALTH INSURANCE.

Small employer health insurance purchasing groups, §§23-86-501 to 23-86-512.

See HEALTH INSURANCE.

SOVEREIGN IMMUNITY.**Insurance.**

Direct action against insurers, §23-79-210.

STATE OF ARKANSAS.**Direct actions against insurer, §23-79-210.****Insurance.**

Direct actions against insurer, §23-79-210.

STATUTE OF LIMITATIONS.**Health insurance portability and accountability, §23-86-302.****Insurance.**

Policies.

Suits against insurers, §23-79-202.

STOCK AND STOCKHOLDERS.**Health maintenance organizations.**

Investments, §23-76-117.

SUBROGATION.**Health insurance.**

Recovery from third parties,
§23-79-146.

Health maintenance organizations.

Recovery from third parties,
§23-79-146.

Hospital and medical service corporations.

Recovery from third parties,
§23-79-146.

Insurance.

Recovery from third parties,
§23-79-146.

SURVIVING SPOUSES.**Insurance.**

Group and blanket health insurance.
Continuation of coverage upon
change in marital status,
§23-86-114.

T**TAXATION.****Exemptions from taxation.**

Fraternal benefit societies, §23-74-504.

Fraternal benefit societies.

Exemptions from taxation, §23-74-504.

Health maintenance organizations.

Premiums and copayments.
Tax on, §23-76-131.

Hospital and medical service corporations.

Exemptions, §23-75-120.
Premium tax, §23-75-119.

TEMPOROMANDIBULAR JOINT DISORDER.**Health insurance.**

Optional coverage to be offered,
§23-79-150.

Health maintenance organizations.

Optional coverage to be offered,
§23-79-150.

Hospital or medical services corporations.

Optional coverage to be offered,
§23-79-150.

TEST TUBE BABIES.**Health insurance.**

In vitro fertilization coverage required,
§23-85-137.

Insurance.

Group and blanket health insurance.
Coverage required, §23-86-118.

TORTS.**Insurance.**

Insured not subject to suit for torts.
Suits against insurers, §23-79-210.

U**UNDERWRITERS.**

Policies of insurance, §23-79-117.

UNFAIR COMPETITION AND TRADE PRACTICES.**Comprehensive health insurance pool.**

Unfair referrals to plan, §23-79-513.

Fraternal benefit societies.

Unfair methods of competition and
unfair and deceptive acts and
practices, §23-74-610.

UNIVERSITIES AND COLLEGES.**Health maintenance organizations.**

Primary care physician required.
Options for students at
postsecondary institutions,
§23-76-132.

V**VENUE.****Insurance.**

Suits against insurers, §23-79-204.

VIATICAL SETTLEMENTS,

§§23-81-601 to 23-81-615.

Advertising, §23-81-611.**Antifraud initiatives, §23-81-612.****Approval of contracts, §23-81-605.****Approval of disclosure statements, §23-81-605.****Audits, §23-81-607.****Civil remedies, §23-81-613.****Criminal violations, §23-81-613.****Definitions, §23-81-602.****Disclosures required, §23-81-608.**

Approval of statement, §23-81-605.

Examination of licensees, §23-81-607.**Fraud prevention and control, §23-81-612.****Licenses.**

Requirements, §23-81-603.

Revocation or denial, §23-81-604.

Notice of viaticated policy, §23-81-609.**Prerequisites to contract, §23-81-609.****Privacy requirements, §23-81-606.****Prohibited contracts, §23-81-610.****Records retention, §23-81-607.****Reports, §23-81-606.****Rulemaking, §23-81-615.****Title of provisions, §23-81-601.****Unfair trade practices, §23-81-614.**

W**WAIVER.****Fraternal benefit societies.**

Laws of societies, §23-74-204.

Insurance.**Policies.**

Claims administration not waiver,
§23-79-127.

WITNESSES.**Insurance.**

Burial associations.

Hearings, §23-78-108.

WORKERS' COMPENSATION.**Notice.**

Increase in premiums, §23-79-151.

